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The Case for Cultural Competency in Psychotherapeutic Interventions

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Abstract

Cultural competency practices have been widely adopted in the mental health field because of the disparities in the quality of services delivered to ethnic minority groups. In this review, we examine the meaning of cultural competency, positions that have been taken in favor of and against it, and the guidelines for its practice in the mental health field. Empirical research that tests the benefits of cultural competency is discussed.

Keywords

cultural adaptation; ethnic minority; evidence-based practice; treatment outcomes; mental health

INTRODUCTION

The notion that culturally competent services should be available to members of ethnic minority groups has been articulated for at least four decades. Multiculturalism, diversity, and cultural competency are currently hot and important topics for mental health professionals (Pistole 2004, Whaley & Davis 2007). Originally conceptualized as cultural responsiveness or sensitivity, cultural competency is now advocated and, at times, mandated by professional organizations; local, state, and federal agencies; and various professions. Yet, the concept has also been a source of controversy concerning its necessity, empirical research base, and political implications. This review examines many of the key issues surrounding cultural competency—namely, its definition, rationale, empirical support, and effects. We have not attempted to be exhaustive in our review of the relevant research; instead, we have examined the major issues and trends in cultural competency.

Many prominent health care organizations are now calling for culturally competent health care and culturally competent professionals (Herman et al. 2004). Appeals for cultural competency grew out of concerns for the status of ethnic minority group populations (i.e., African Americans, American Indians and Alaska Natives, Asian Americans, and Hispanics). These concerns were prompted by the growing diversity of the U.S. population, which necessitated changes in the mental health system to meet the different needs of multicultural populations.

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DISCLOSURE STATEMENT

The authors are not aware of any biases that might be perceived as affecting the objectivity of this review.

Further troubling were the well-documented health status disparities between different ethnic and racial groups, as well as the nationally publicized studies regarding cultural bias in health care decision making and recommendations (Schulman et al. 1999). The evidence revealed that mental health services were not accessible, available, or effectively delivered to these populations. Compared to white Americans, ethnic minority groups were found to underutilize services or prematurely terminate treatment (Pole et al. 2008, Sue 1998). Racial and ethnic minorities receive a lower quality of health care than do nonminorities, have less access to care, and are not as likely to be given effective, state-of-the-art treatments (U.S. Surgeon General 2001). The disparities exist because of service inadequacies rather than any possible differences in need for services or access-related factors, such as insurance status (Smedley et al. 2003).

Justice or ethical grounds have also propelled cultural competency (Whaley & Davis 2007). The goals of many professional organizations include equity and fairness in the delivery of services. For example, one of the guiding principles of the American Psychological Association (2002, pp. 1062–1063) is that:

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Ridley (1985) has argued that cultural competence is an ethical obligation and that crosscultural skills should be placed on a level of parity with other specialized therapeutic skills. As an alternative to the passive “do no harm” approach in ethical standards in many helping professions, Hall et al. (2003) advocated that ethical standards mandate cultural competence via collaboration with, and sometimes deference to, ethnic minority communities and experts.

The delivery of quality services is especially difficult because of cultural and institutional influences that determine the nature of services. For example, Bernal & Scharroón-Del-Río (2001) maintain that ethnic and cultural factors should be considered in psychosocial treatments for many reasons. They propose that psychotherapy itself is a cultural phenomenon that plays a key role in the treatment process. In addition, ethnic and cultural concepts may clash with mainstream values inherent to traditional psychotherapies. The sources of treatment disparities are complex, are based on historic and contemporary inequities, and involve many players at several different levels, including health systems, their administrative and bureaucratic processes, utilization managers, health care professionals, and patients (Smedley et al. 2003).

Although the problems giving rise to the cultural competency movement are multifaceted, our focus in this review is to analyze therapist and treatment tactics that are considered culturally competent. In the focus on cultural competency, we acknowledge the social and psychological diversity that exists among members of any ethnic minority group and the tendency to generalize information across distinct ethnic groups. The discussion of cultural competence issues for a particular ethnic minority group becomes even more challenging in view of the limited amount of empirically based information available on cultural influences in mental health treatment. Considering these limitations, we proceed as judiciously as we can, examining key cultural tendencies and issues likely to be encountered in psychotherapy and counseling, drawing out some implications from the extant research, and offering some suggestions for research that may produce more culturally informed mental health practices. We also recognize that culture is only one relevant factor in providing effective mental health treatment and that depending on the circumstances, other aspects of clients may be more influential. The literature reviewed represents trends that have been observed and should be

considered as guidelines or working hypotheses often linked with culturally competent mental health care for ethnic minority clientele.

WHAT IS CULTURAL COMPETENCY?

From the outset, we want to indicate that our coverage is limited. In cultural competence, it is important to distinguish between three levels of analysis: provider and treatment level, agency or institutional level (e.g., the operations of a mental health agency), and systems level (e.g., systems of care in a community). Our focus is on the first level—that of the provider, therapist, or counselor and that of the specific treatment used.

To evaluate the validity, utility, and empirical basis of cultural competency, one must first be able to define the construct. Competence is usually defined as an ability to perform a task or the quality of being adequately prepared or qualified. If therapists or counselors are generally competent to conduct psychotherapy, they should be able to demonstrate their skills with a range of culturally diverse clients. Proponents of cultural competency, however, believe that competency is largely a relative skill or quality, depending on one's cultural expertise or orientation. Their definitions of cultural competency assume that expertise or effectiveness in treatment can differ according to the client's ethnic or racial group. As Hall (2001) noted, advocates of cultural competency or sensitivity appreciate the importance of cultural mechanisms and argue that simply exporting a method from one cultural group to another is inadequate.

Can Cultural Competency be Distinguished from Competency in General?

Is there evidence that cultural competency can be distinguished from competency in general? The two may overlap but also have some distinct effects. Fuertes and colleagues (2006) found that ethnic minority clients rated their therapists as being higher in multicultural competency if the therapists were rated high on therapeutic alliance and empathy. These two characteristics are considered good ingredients in all treatments. Fuertes et al. (2006) recommend that therapists receive training in traditional areas such as relationship building and in communicating empathy. At the same time, they believe it is important that therapists be trained to competently handle the culturebased concerns that their clients bring to therapy. Another study suggests that the two are somewhat distinct. Constantine (2002) correlated African American, American Indian, Asian American, and Hispanic clients' treatment satisfaction with two measures of competency: one that assessed counselors' competency in general (i.e., the Counselor Rating Form–Short) and the other that measured cross-cultural competence in particular (Cross-Cultural Counseling Inventory–Revised). Although the two well-established competency measures were somewhat related, the cross-cultural competency measure contributed significantly to client satisfaction beyond general competency. There was also evidence that ethnic minority clients' perceptions of their counselors' multicultural counseling competence partially mediated the relationship between general counseling competence ratings and satisfaction with counseling. Thus, cultural competency may be meaningfully distinguished from competency in general.

Differing Definitions

But how does one define the concept? In the past, terms such as “cultural sensitivity,” “cultural responsiveness,” and “multicultural competence” were used to convey the significance of attending to cultural issues in therapy and counseling. Despite consensus over the importance and significance of cultural values and behaviors in treatment, investigators have actually varied in their specific assumptions or focus for cultural competency. Many models of culturally sensitive therapy have been developed (Hall et al. 2003). Some describe characteristics of cultural competency. For example, ingredients viewed by some as essential

for cultural competence include having an understanding, appreciation, and respect for cultural differences and similarities within, among, and between culturally diverse patient groups (U.S. Dept. Health Human Serv. 2002). Culturally competent care has been defined as a system that acknowledges the importance and incorporation of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs (Whaley & Davis 2007).

Others emphasize the outcome of cultural expertise. Thus, having cultural knowledge or skills is important to the extent that positive outcomes are achieved, such as:

- The capacity to perform and obtain positive clinical outcomes in cross-cultural encounters (Lo & Fung 2003).
- The acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (i.e., the ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds) (Alvarez & Chen 2008, D.W. Sue & Torino 2005).
- The possession of cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture (S. Sue 1998).
- The ability to work effectively in crosscultural situations using a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals (Agency for Healthcare Research and Quality 2004).

Although the varying definitions overlap to some degree, one meaningful way of conceptualizing the definitions of competency is to note that some emphasize the (a) kind of person one is, (b) skills or intervention tactics that one uses, or (c) processes involved. In terms of the kind of person one is, D.W. Sue and colleagues (Sue et al. 1982, 1992) argue that the culturally competent counselor has:

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

In this view, cultural competency involves a constellation of the right personal characteristics (awareness, knowledge, and skills) that a counselor or therapist should have. Every counselor should possess these characteristics. This model for cultural competency is the most widely recognized framework, and it formed the basis for much of the multicultural guidelines adopted by the American Psychological Association (Am. Psychol. Assoc. 2003) as well as the multicultural counseling competencies adopted by the organization's Division 17.

The skills or tactics model views cultural competency as a skill to be learned or a strategy to use in working with culturally diverse clients. One chooses to exercise the skill or to use a cultural adaptation under the appropriate circumstances. Cultural competency is essentially similar to other specialized therapeutic skills such as expertise in sexual dysfunctions and depressive disorders (Ridley 1985). In this view, acquisition of multicultural competence would involve in-depth training and supervised experience as found in the development of other psychotherapeutic competencies (Whaley & Davis 2007).

Finally, process-oriented models focus on the complex client-therapist-treatment interactions and processes involved. For example, López (1997) considers the essence of cultural competence to be “the ability of the therapist to move between two cultural perspectives in understanding the culturally based meaning of clients from diverse cultural backgrounds” (p. 573). S. Sue (1998) views cultural competence as a multidimensional process. He proposes that three important characteristics underlie cultural competency among providers: scientific mindedness (i.e., forming and testing hypotheses), dynamic sizing (i.e., flexibility in generalizing and individualizing), and culturespecific resources (i.e., having knowledge and skills to work with other cultures) in response to different kinds of clients.

The definitions of cultural competence have points of convergence and divergence (Whaley & Davis 2007). They all agree that knowledge, skills, and problem solving germane to the cultural background of the help seeker are fundamental. Nevertheless, the different definitions vary with respect to their emphasis on global characteristics, knowledge, skills, awareness, problem-solving abilities, aspirations, processes, etc. The definitions also vary as to how amenable they are to research testing. The kind-of-person model and the process model pose problems in terms of empirical testing. In both models, characteristics of culturally competent therapists or interacting processes are difficult to specify and operationalize for research. On the other hand, the skills or cultural adaptation model can be more readily tested. In this model, researchers introduce the skill or cultural adaptation of treatment and compare the effects with other treatment or no-treatment control groups.

In general, it has been difficult to develop research strategies, isolate components, devise theories of cultural competency, and implement training strategies. Some limitations in cultural sensitivity or competency are that it (*a*) has various meanings, (*b*) includes inadequate descriptors, (*c*) is not theoretically grounded, and (*d*) is restricted by a lack of measurements and research designs for evaluating its impact in treatment.

RESISTANCE TO CULTURAL COMPETENCY

It is not surprising that cultural competency or multiculturalism has come under attack. Because of the lack of research on cultural competency, some have challenged it as being motivated by “political correctness” (Satel & Forster 1999) and untested in clinical trials (Satel 2000).

One of the important debates in the literature concerning cultural competency can be found in the attempt to establish multicultural counseling competencies or multicultural guidelines for the American Mental Health Counseling Association. The guidelines, many of which are highly similar to the ones adopted by the American Psychological Association (2003), stimulated civil but contentious exchanges. The debated issues revolved around several key questions, articulated largely by Thomas & Weinrach (2004), Weinrach & Thomas (2002, 2004), Vontress & Jackson (2004), and Patterson (2004):

1. Are cultural competency proponents stereotyping ethnic minority clients?

Because cultural competency advocates emphasize the need to understand the cultural values and worldviews of members of different cultural groups, Weinrach & Thomas (2002, 2004) have suggested that the position that members of these groups behave similarly is inadvertently racist, stereotypic, and prejudicial. Herman et al. (2007) and Hwang (2006) made similar points more recently. They ask whether it is possible to conduct culturally competent counseling given the risks associated with implementing counseling in a manner that fails to attend to a client’s individual differences and inadvertently promotes culture-related stereotypes of clients. For example, important individual differences among American Indian clients include ethnic identity, acculturation,

residential situation, and tribal background (Trimble 2003, 2008). By addressing presumed cultural orientations of, say, American Indians, therapists may fail to consider acculturated American Indian clients who do not hold traditional Native American perspectives.

2. By advocating for multicultural competencies for ethnic minority groups, are we discriminating against or ignoring other diversity characteristics such as gender, sexual orientation, and social class?

The cultural competency movement, for the most part, has been addressed to the needs of African Americans, American Indians and Native Alaskans, Asian Americans, and Hispanics. Weinrach & Thomas (2002) believe that the designation of only a few minority groups as worthy of the profession's attention is profoundly demeaning to those minorities not included and that the concerns of other diverse populations, such as women and persons with disabilities, are ignored.

3. Is the role of culture and minority group status in mental health overemphasized in multiculturalism?

Weinrach & Thomas (2002, 2004) have also raised the issue that multicultural proponents have emphasized that external or environmental forces, such as racism and oppression, largely cause clients' emotional disturbance. Intrapyschic causes are minimized. Weinrach & Thomas argue that a focus on race is an outmoded notion. Race does not provide an adequate explanation of the human condition. Attempts to invoke race as such have been appropriately labeled as racist and inadvertently contribute to America's preoccupation with the pigmentation of a person's skin. Vontress & Jackson (2004) maintain that mental health counselors should look at all factors that affect a client's situation. Race may or may not be one of them. They believe that in general, race is not the real problem in the United States today. The significance that clients attach to it is the most important consideration. However, Vontress & Jackson (2004) believe that in this country, the attention given to discussing cultural differences and similarities is good for society and for our profession.

Finally, Patterson (2004) is concerned over the emphasis on cultural differences. He notes that it has not been fruitful to assume that simply having knowledge of the culture of the client will lead to more appropriate and effective therapy. The first faulty assumption is that counseling or psychotherapy is a matter of information, knowledge, practices, skills, or techniques. Rather, the competent mental health counselor is one who provides an effective therapeutic relationship. The second faulty assumption is that client differences are more important than client similarities. He argues that a treatment such as client-centered therapy is a universal system that cuts across cultures. However, methods that are considered universal usually are Western methods that are assumed to apply to other groups. Most Western therapeutic methods rely heavily on verbal and emotional expression. Yet, among persons of East Asian ancestry, talking has been found to interfere with thinking (Kim 2002), and emotional expression may be dependent on cultural norms (Chentsova-Dutton et al. 2007). In fact, recent research indicates that the psychological consequences of emotional suppression and control can differ depending on the cultural context (Butler et al. 2007).

4. Is the emotional and political context of the debate creating incivility?

Weinrach & Thomas (2004) have indicated that support for cultural competency, created as a logical consequence of the 1960s civil rights movement, is often used

as a litmus test of one's commitment to a nonracist society. Weinrach & Thomas (2004, pp. 90–91) state:

Among other goals, they were intended to sensitize White mental health professionals to the unique cultural distinctiveness of male clients on the basis of membership in four visible minority groups. At the symbolic level, they have successfully brought to professional counselors' awareness the importance of attending to the diverse counseling needs of visible minorities. On the applied level, they have been a failure, as we see it. We would prefer to see their demise in order to foster the recognition that client needs should not be assumed to be based upon group membership alone, but rather on the unique constellation of individual client characteristics, including but not limited to cultural distinctiveness.

They lament the fact that persons who refuse to adopt the competencies may be accused of displaying "unintentional racism" or the results of "the insidious ethnocentric aspect of our cultural conditioning" (see Ivey & Ivey 1997, D.W. Sue 1996).

Although heated at times, the debates in the literature have been instructive. First, they help to clarify positions and misunderstandings. For example, most advocates of cultural competency do not see external factors (e.g., racism) as the sole or primary cause of mental disorders or that attention to ethnicity and race lessens concern over other diversity or individual differences (e.g., gender, sexual orientation, social class, etc.) factors (Arredondo & Toporek 2004, Coleman 2004). They recognize individual differences within various ethnic groups, such as the multitude of groups considered Hispanic (e.g., Mexican, Puerto Rican, and Cuban American). Even within a particular group, such as Mexican Americans, there may be considerable variations in level of acculturation that affect the outcomes of cultural competency interventions, as we note below. The emphasis on ethnicity and race is a reaction to centuries of ethnocentric bias against, and inattention to, the importance of culture and minority group status. If, as Bernal & Scharrón-Del-Río (2001) have argued, psychotherapy itself is a cultural phenomenon, ethnic minority concepts may conflict with mainstream values inherent to traditional psychotherapies. Cultural values of interdependence and spirituality, and discrimination in the psychotherapy of ethnic minorities, are often ignored in treatment approaches to ethnic minority clients (Hall 2001). In order to achieve the ecological validity of interventions, these cultural values must be considered in all treatments (Bernal 2006). Given the growing ethnic minority populations and the existing disparities in health and treatment, special attention to race and ethnicity is needed.

Second, there is no single multicultural orientation or cultural competency viewpoint, as noted in our discussion of the definitions of cultural competency. Yet, critics often attack cultural competency by characterizing it with extreme positions (a straw man approach). Satel & Forster (1999) have asserted that the most radical vision of cultural competence claims that membership in an oppressed group is a client's most clinically important attribute. This assertion is misleading because few, if any, would advocate such a view. In addition, cultural competency tactics appear to vary according to the kind of client and the kind of disorders experienced by the client (discussed below).

Third, discussions of culture, ethnicity and race, and multiculturalism are frequently heated and emotional. Emotional reactions to the issues are not unexpected. Race and ethnicity have been highly controversial throughout the history of the United States. As noted by Pope-Davis et al. (2001, pp. 128–129):

It is our contention that multiculturalism is infused with political meaning. The word itself is a symbol—a trigger—of change that often elicits a range of emotional responses... We believe that it is also important to acknowledge that, given the history

of psychology's inadequacies with diverse populations, multiculturalism is not an apoliticized theory. Much of the research done in the multicultural arena attempts to shift current thinking and institutional practices toward greater equality and recognition of diverse needs and perspectives. This agenda... implicates the subjective motivation of the researchers in the product.

Finally, much consensus exists over the necessity for more research and over the multitude of unanswered questions and issues. Ridley et al. (1994) indicate that cultural competency lacks theoretical grounding and adequate measures of the construct. Moreover, little research examines ethnic variations in response to treatment (Mak et al. 2007). Despite the questions raised over cultural competency adaptations, the magnitude of mental health disparities in access to and quality of services for ethnic minority populations has spurred actions to address the problems.

WHAT HAS BEEN ACCOMPLISHED SO FAR?

Awareness of treatment disparities and the effects on mental health have stimulated the establishment of local, state, and federal guidelines for the delivery of culturally competent services. For example, the following federal agencies are among the many that have Websites that explain their cultural competency recommendations and guidelines:

- Administration on Aging, U.S. Department of Health & Human Services (HHS) (http://www.aoa.dhhs.gov/prof/adddiv/cultural/addiv_cult.asp)
- Office of Minority Health, HHS (<http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3>)
- Health Resources and Services Administration (<http://www.hrsa.gov/culturalcompetence/>)
- Substance Abuse and Mental Health Services Administration (<http://mentalhealth.samhsa.gov/dtac/CulturalCompetency.asp>)

In terms of psychology organizations, counseling psychologists were among the first to extensively discuss and debate cultural competency issues through organizations such as the Association for Non-White Concerns in Personnel and Guidance in the 1970s and the Association for Multicultural Counseling and Development in the 1980s. Subsequently, many counseling psychologists through APA Division 17 (Counseling Psychology) and the National Institute for Multicultural Competence advocated for multicultural guidelines. Among clinical psychologists, APA Division 12 (Society of Clinical Psychology) established the section on the Clinical Psychology of Ethnic Minorities.

The APA has also had a history of involvement in ethnic, culture, and professional practice. The adoption of the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* had implications not only for mental health services but also for education, training, and research (Am. Psychol. Assoc. 2003). These guidelines provided a context for service delivery: "Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices..." (p. 390). Cross-culturally sensitive practitioners are encouraged to develop skills and practices that are attuned to the unique worldviews and cultural backgrounds of clients by striving to incorporate understanding of a client's ethnic, linguistic, racial, and cultural background into therapy" (p. 391).

Other professional organizations have issued statements, guidelines, or policies regarding cultural competency. For example, the American Psychiatric Association's Steering Committee to Reduce Disparities in Access to Psychiatric Care (2004) developed an action

plan to reduce disparities and to increase cultural awareness. Similarly, the National Association of Social Workers defined cultural competency as a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in multicultural situations. It then developed standards for cultural competence in social work practice (Natl. Assoc. Social Workers 2007).

In the past two decades, cultural competency has been mandated to reduce mental health disparities; at the very least, cultural competency is recommended by various institutions, governmental bodies, and professional organizations. However, the mandates are rather hortatory or aspirational in nature because precise tactics and implementation strategies are unclear. Research is needed to gain knowledge about what works in cultural competency and how it works. It should be noted that most definitions of cultural competency do not include treatment outcomes as the major criteria for competence. This is surprising since it seems reasonable that if certain therapist skills or orientations are more culturally competent, these should be related to better treatment outcomes for ethnic minority clients (or at the minimum, equitable outcomes relative to those of mainstream clients). The proliferation of operational definitions of cultural competence may stem from the fact that these notions of competence have not been held empirically accountable to treatment outcomes—the gold standard (U.S. Surgeon General 2001).

We indicate below the kinds of interventions that characterize cultural competency. We examine the research studies that have tested the effects of culturally competent interventions and discuss outcomes of these studies in the final section.

WHAT KINDS OF CULTURAL COMPETENCY INTERVENTIONS HAVE BEEN ATTEMPTED?

Considerable variation exists in the studies of culturally competent interventions. The interventions have ranged in terms of:

- Intervention approach. A narrow intervention is changing a specific feature of standard treatment practice such as conducting treatment in the ethnic language of the client. Broader interventions are those in which the general treatment approach is determined by the client's ethnicity or in which many different features are based on cultural considerations (e.g., not only having a language match between client and therapist but also an ethnic and cultural match).
- Client problems and issues (e.g., rape prevention, treatment of schizophrenia, prevention of drug abuse, depression, and self-esteem).
- Ethnic/racial groups (African American, American Indian and Alaskan Natives, Asian Americans, and Hispanics). Most studies have been conducted on African Americans and Hispanics. Very few have included American Indians and Alaskan Natives. Some investigations involve more than one ethnic/racial group.
- Intervention type. Studies vary according to individual versus group interventions, treatment versus prevention, and use of standard treatments (e.g., cognitive behavioral treatment) versus specially developed interventions (e.g., *cuento* therapy for Puerto Ricans).

The studies also vary considerably on the type of research design (experimental, correlational, and archival), outcome measures used, the inclusion of control or alternative intervention groups, rigor in design, follow-up assessment, and sample size. In any event, we have classified the studies into certain categories for heuristic purposes only. We discuss culture competency

in terms of method of delivery, content, and specialized interventions, which have been programmatically examined, such as cognitive behavioral treatments, storytelling interventions, and family therapies.

Method of Delivery

Method of delivery is intended to make the intervention more culturally consistent, increase credibility of the treatment or provider, or make the treatment understandable to ethnic minority clients. Delivery methods include intervention tactics that respond to the ethnic language of clients (e.g., translating materials or having bilingual therapists), varying the interpersonal style of the intervention (e.g., showing *respeto* or culturally appropriate respect with Hispanics), or providing a cultural context for interventions (Andrés-Hyman et al. 2006). These changes share a common feature in that they involve generic applications; they can be implemented across most types of treatment (e.g., psychodynamic, behavioral, and cognitive-behavioral).

A minimum requirement of the intervention is that therapists must be able to communicate with clients in a manner that is culturally acceptable and appropriate. Clients who have limited English proficiency have difficulties entering, continuing, and benefiting from treatment (Snowden et al. 2007) and appear to need culturally adapted interventions more than do clients who are acculturated and have greater English proficiency (Sue et al. 1991). A number of investigations used therapists who speak the ethnic language of clients who have limited English proficiency. These studies explicitly report that treatment was conducted by therapists who were bilingual or who spoke the language of their clients. The languages have included Spanish (e.g., Armengol 1999, Gallagher-Thompson et al. 2001, Guinn & Vincent 2002, Kopelowicz et al. 2003, Martinez & Eddy 2005), Korean (Shin 2004, Shin & Lukens 2002), and Chinese (Dai et al. 1999). Some studies attempted to see if ethnic match or a related form of match (e.g., cognitive match) between provider and client affected intervention outcomes or processes (Campbell & Alexander 2002, Flaskerud 1986, Flaskerud & Hu 1994, Mathews et al. 2002, Sue et al. 1991, Takeuchi et al. 1995, Zane et al. 2005). Rather than examining specific therapist-client matches in language or other aspects, some studies have simply examined institutional resources (e.g., the extent to which agencies had therapists who could conduct treatment in the ethnic language of clients) and then correlated treatment outcomes for ethnic clients (Campbell & Alexander 2002, Flaskerud 1986, Flaskerud & Hu 1994, Gamst et al. 2003, Lau & Zane 2000, S. Sue et al. 1991, Yeh et al. 1994). In all of the studies, it is difficult to ascertain the precise factors that account for client outcomes. As mentioned above, most investigations have included many different features of cultural competency, and language was only one of them. For example, having bilingual staff may provide not only language match but also cultural or ethnic match.

Besides language, other cultural competency adaptations were reflected in communication patterns. For instance, patterns of interactions common among less-acculturated Hispanic/Latinos were followed in Armengol's (1999) study involving support group therapy. A formal mode of address was used if that was the stated preference of participants. Even when first names were preferred, the more formal personal pronoun form of "you" (i.e., "*usted*") was employed. Participants also addressed the group facilitator by her professional title (*Doctora*), even when using her first name. The use of such practices is consistent with cultural values involving *respeto* and deference toward authority figures. These communication patterns have also been employed in other intervention strategies such as cognitive behavioral treatment and interpersonal psychotherapy (Miranda et al. 2003a, Rossello et al. 2008). Although showing respect is desirable regardless of the client's culture, knowledge of the culture determines how effectively that respect is shown and delivered.

In some intervention approaches, culturally consistent adaptations have involved the initiation of ceremonies that reflect cultural rituals such as a unity circle, a drum call, the pouring of

libation to the ancestors, and a blessing for the day, which are African-based rituals (Harvey & Hill 2004), and use of ethnic foods during intervention (Longshore & Grills 2000).

Content

Content refers to the discussion of, or dealing with, cultural patterns, immigration, minority status, racism, and cultural background experiences in the intervention. The introduction of content may serve to increase understandability and credibility of the intervention and to demonstrate the pertinence of the intervention to the real-life problems experienced by clients (Ponterotto et al. 2006). Most interventions have both delivery and content elements. For example, in a culturally adapted management training intervention for Latino parents, Martinez & Eddy (2005) not only conducted training sessions in Spanish but also addressed culturally relevant immigration and acculturation issues. Similarly, relevant cultural content was included in a support group intervention for Hispanic traumatic brain injury survivors (Armengol 1999) and in an educational intervention program for low-acculturated Latinas (Guinn & Vincent 2002). The interventions included discussions of language, acculturation, spirituality, stressors inherent in the migratory experience, attitudes and beliefs about disability and health care, and support networks.

Interventions involving African American girls (Belgrave 2002, Belgrave et al. 2000), youths (Cherry et al. 1998, Harvey & Hill 2004, Jackson-Gilfort et al. 2001), and adults (Longshore & Grills 2000) have incorporated principles of spirituality, harmony, collective responsibility, oral tradition, holistic approach, experiences with prejudice and discrimination, racial socialization, and interpersonal/communal orientation that are often found in African American worldviews. In a rape prevention program that included many African Americans, Heppner et al. (1999) introduced culturally relevant content (e.g., including specific information about race-related rape myths and statistics on prevalence rates for both blacks and whites and having black and white guest speakers discuss their sexual violence experiences in a cultural context to increase the personal relevancy of the message). Robinson et al. (2003) studied the effects of school-based health center programs for African American students. All of the programs were intended to promote an African American atmosphere and theme. Features ranged from having school decorations and posters (representing Afrocentric perspectives and positive African American role models) to employing African American staff and tailoring services to be delivered in a culturally sensitive manner.

Culturally adapted content has also been used with other ethnic minority groups such as American Indians and Alaska Natives (De Coteau et al. 2006). Fisher et al. (1996) used spiritual groups and cultural awareness training in a residential treatment program in Alaska. Schinke et al. (1988) provided biculturally relevant examples of verbal and nonverbal means of refusing substance use. For instance, leaders modeled how subjects could turn down offers of tobacco, alcohol, and drugs from peers without offending their American Indian and non-American Indian friends. While subjects practiced their communication skills, leaders offered coaching, feedback, and praise. Zane and colleagues (1998) report an example of a preventive intervention program for Asian Americans. The program was intended to prevent substance use and to increase the resiliency of high-risk Asian youths and their families. Group discussions and skill-building exercises for youths focused on Asian familial values, acculturation issues, and intergenerational communication. Parents participated in small-group workshops that also included topics involving cultural values, intergenerational communication, and family.

The studies indicate that cultural competency adaptations can range from simply providing ethnic language provisions to introducing multifaceted changes in intervention philosophy, delivery, and format. Some studies compared cultural adaptations to no-intervention or no-adaptation control groups. Furthermore, components of cultural competency were not

subjected to testing, so it is not possible to attribute possible positive effects of intervention to any particular component (e.g., determining whether treatment outcomes were caused by ethnic language translations or introduction of particular ethnic contents). Before we examine the outcome of cultural competency interventions, we discuss specific kinds of interventions, developed through more programmatic research, that have used cultural adaptations: storytelling, family interventions, and cognitive behavioral therapy.

Storytelling

Many Latinos answer questions by telling a story, thereby allowing the answer to emerge out of their narrative (Comas-Díaz 2006). In order to improve the self-concept, emotional well-being, and adaptive behaviors of Puerto Rican children, researchers (Costantino et al. 1986; Malgady et al. 1990a, b) used *cuentos* (Puerto Rican folktales) or biographies of heroic persons. Folktales often convey a message or a moral to be emulated by others. The investigators incorporated themes such as social judgment, control of aggression, and delay of gratification within Puerto Rican American culture and experiences. By presenting culturally familiar characters of the same ethnicity as the children, they felt that the folktales would serve to motivate attentional processes; make it easier to identify with the beliefs, values, and behaviors portrayed in the adapted *cuentos*; and model functional relationships with parental figures. Therapists, mothers, or group leaders read the *cuentos* bilingually, typically to children at risk for emotional or behavioral problems.

The research designs of the studies often compared adapted *cuento* intervention with original folktales (not adapted to U.S. experiences) to other forms of intervention (e.g., art/play therapy) or to a no-intervention control group. Children were randomly assigned to groups. Results across the various studies yielded favorable emotional and behavioral outcomes for the adapted *cuento* intervention compared with the other groups.

Family

Szapocznik, Santisteban, and their colleagues (Santisteban et al. 1997, 2003, 2006; Szapocznik et al. 1984, 1986, 1989, 1990, 2003) have systematically investigated the effects of specially designed, culturally adapted treatment interventions in families. Brief structural family therapy (BSFT) is an integration of structural and strategic theory and principles. BSFT was created because it was found to be adaptable and acceptable for work with Hispanic families. The investigators believe that the modality is especially suited to the needs of the targeted populations because it emerged out of experience in working with urban minority group families (particularly African American and Puerto Rican) that were disadvantaged in terms of social, cultural, educational, and political position in American society. Some components of the model are used with all families, and others are family specific and may be unique to certain cultural groups (i.e., immigration issues, racial prejudice issues). In BSFT, therapists take an active, directive, present-oriented leadership role that matches the expectations of the population.

Moreover, a structural family approach is consistent with Hispanics' preference for clearly delineated hierarchies within the family. BSFT was able to directly address common acculturation-related stressors, such as acculturation differences and intergenerational conflicts between children and their parents. Research designs for the studies of BSFT often included randomized control trials. In general, BSFT was found to be as good as or (typically) superior to control conditions in reducing parent and youth reports of problems associated with conduct, family functioning, and treatment engagement.

Cognitive Behavioral Therapy

A number of studies have examined whether culturally adapted forms of cognitive behavioral therapy (CBT) are more effective than are nonadapted forms of CBT, whether culturally adapted treatment demonstrates positive outcomes, or whether certain components of CBT are more helpful than others (Jackson et al. 2006, Shen et al. 2006). These studies are important because CBT is effective for many different problems (e.g., anxiety and depression) and for different ethnic populations. Furthermore, because CBT is often delivered with a fixed format or manualized script, it can readily incorporate cultural adaptations and be tested. For example, Kohn and colleagues (2002) examined the degree to which a manualized CBT intervention could be adapted in a culturally sensitive manner in treating depressed low-income African American women experiencing multiple stressors. The adaptations included changes in the language used to describe cognitive-behavioral techniques and inclusion of culturally specific content (e.g., African American family issues) in order to better situate the intervention in an African American context. Compared with a nonadapted CBT intervention group, women in the adapted CBT group exhibited a larger drop in depression. De Coteau et al. (2006) have offered general guidelines for modifying manualized treatments that are particularly applicable to Native Americans living on reservations or in rural tribal communities.

Miranda and her colleagues (2003a) have studied whether cultural adaptations to CBT improve the outcomes of treatment for Hispanics. In randomized trials, the adapted form of CBT consisted of having bilingual and bicultural providers, translating all materials into Spanish, training staff to show *respeto* and *simpatia* to patients, and allowing for somewhat warmer, more personalized interactions than are typical for English-speaking patients. These adaptations were considered to be culturally responsive. The patients who received the adapted CBT had lower dropout rates than those who received CBT alone. There was indication that the effects of adapted CBT were stronger among those whose first language was Spanish rather than English in terms of greater improvement in symptoms and functioning.

Miranda et al. (2003b) have also shown that quality improvement interventions for depressed primary care patients can improve treatment outcomes for ethnic minority groups. Because ethnic minority clients often receive poorer quality of services than do white clients (U.S. Surgeon General 2001), the investigators wanted to study the effects of quality improvements to care. The culturally adapted improvements included the availability of materials in English and Spanish. Hispanic and African American providers were included in videotaped materials for patients. In addition, providers were given training materials that dealt with cultural beliefs and ways of overcoming barriers to care for Latino and African American patients. The quality improvement interventions resulted in beneficial outcomes. However, because the study included general improvements as well as culturally relevant interventions, it was not possible to determine what factors in the interventions caused the favorable outcomes.

Rossello & Bernal (1999) found that cultural adaptations to CBT and interpersonal psychotherapy (IPT) were more effective than a wait-list control group in reducing depression among Puerto Rican youths. Rossello et al. (2008) maintain that certain treatment approaches, such as CBT and IPT, may intrinsically appeal to the cultural orientation of Latinos. CBT has (a) a didactic orientation that provides structure to treatment and education about the therapeutic process; (b) a classroom format that reduces the stigma of psychotherapy; (c) a match with client expectations of receiving a directive and active intervention from the provider; (d) an orientation focused on the present and on problem solving; and (e) concrete solutions and techniques to be used when facing problems. On the other hand, IPT focuses largely on the present interpersonal conflicts that are pertinent to Latino values of *familismo* (family) and *personalismo* (personal considerations). The congruence of CBT and IPT with Latino values made it easier for the investigators to adapt them for use with Puerto Rican adolescents. The adolescents were randomly assigned to CBT (individual or group treatment)

or IPT (individual or group treatment). Results revealed that all groups demonstrated decreases in depressive symptoms with CBT that were superior to IPT.

Other studies have introduced cultural adaptations in cognitive behavioral training. Gallagher-Thompson et al. (2001) designed a culturally sensitive eight-week class that taught specific cognitive and behavioral skills for coping with the frustrations associated with caregiving. Hispanic caregivers of dementia victims were assigned to the training class or to a waitlist control group. At the end of the intervention, trained caregivers reported significantly fewer depressive symptoms than did those in the control group. Hinton et al. (2005) has also used CBT to treat Cambodian refugees by using culturally appropriate visualization tasks.

Findings from the CBT studies provide consistent indication that cultural competency interventions are effective, and two of the studies (Kohn et al. 2002, Miranda et al. 2003a) found that cultural competency adaptations to CBT were superior to nonadapted CBT.

IS TREATMENT GENERALLY EFFECTIVE WITH ETHNIC MINORITY POPULATIONS?

As mentioned above, ethnic and racial disparities exist in treatment access and quality. Does this mean that treatment is not effective with ethnic minority populations or that ethnic clients should not seek treatment for mental health problems? Despite the disparities, treatment is needed and can be helpful for all populations (President's New Freedom Commission 2003, U.S. Surgeon General 2001). Ethnic minority populations need access to the best forms of treatment. The questions to be answered include what are the best forms of treatment for ethnic minority populations and whether cultural competency interventions add to positive treatment outcomes.

In the mental health field, widespread attempts have been made to define the best forms of treatment. Outcomes of mental health care are evaluated through two types of research, efficacy and effectiveness studies (Miranda et al. 2005). Efficacy studies, or randomized, controlled trials, are valuable in determining the treatment factors that determine outcomes. They are designed to maximize internal validity and are rigorously conducted, often in strictly controlled settings. Effectiveness research is typically conducted in more real-life situations and may not achieve the rigor and controls found in efficacy studies. It often provides greater external validity than internal validity compared to efficacy studies. Efficacy and effectiveness research is used to guide treatment recommendations. The use of research to establish best practices has resulted in the designation of evidence-based practices (EBPs) and empirically supported treatments (ESTs). EBPs are those psychotherapeutic practices that have demonstrated value through either effectiveness or efficacy research. ESTs are certain types of EBPs that have been shown through rigorous efficacy research to result in positive outcomes. However, little research has been conducted on the value of EBPs and ESTs for ethnic minority populations (Constantine et al. 2008). As late as 1996, Chambless and colleagues (1996) could not find even one EST study that analyzed ethnicity as a variable. More recently, Mak et al. (2007) conducted a review of clinical trial studies. They found that most of the studies reported gender information, and gender representation was balanced across studies. However, less than half of the studies provided complete racial/ethnic information with respect to their samples. Except for whites and African Americans, all racial/ethnic groups were underrepresented, and less than half of the studies had potential for subgroup analyses by gender and race/ethnicity (Mak et al. 2007). Given the paucity of research, the external validity of EBPs has not been clearly established (Whaley & Davis 2007). The lack of research has led many to conclude that the answers are still unclear as to whether EBPs and ESTs are effective with these populations and the conditions under which such treatments are beneficial (Castro et al. 2004, Sue & Zane 2006).

Studies of treatment and preventive intervention effects for ethnic minorities were reviewed by Miranda et al. (2005). In general, their review concluded that EBPs were effective with different ethnic minority groups and ethnic minority children and adults for a wide range of mental disorders and problem behaviors (e.g., depression, anxiety, and family problems). A meta-analysis of evidence-based treatments for ethnic minority youths was conducted by Huey & Polo (2008). They found that these interventions produced positive overall treatment effects of medium magnitude. However, the investigators raised the possibility that the EBPs and ESTs may sometimes have included cultural adaptations such as performing the interventions in the cultural context of the client, using the client's ethnic language, or integrating cultural elements. We do not know the extent to which research studies use culturally adapted elements but fail to report them. Given the preponderance of evidence that EBPs and ESTs are often effective, are culturally competent adaptations needed?

DO CULTURAL COMPETENCY ADAPTATIONS DEMONSTRATE POSITIVE AND INCREMENTAL EFFECTS ON TREATMENT?

What does research reveal about the effects of cultural competency interventions? Two metaanalyses are pertinent to this question. Griner & Smith (2006) directly examined the effects of cultural competency interventions. Huey & Polo (2008) confined their meta-analysis to ethnic minority youths and indirectly addressed the question after examining the outcomes of evidence-based treatments (and not necessarily cultural-competency studies) for ethnic minority youths.

Because Griner & Smith (2006) is the only meta-analysis to date that has examined the effects of culturally competent interventions, we want to elaborate on its findings. Their metaanalysis revealed that there are controlled, experimental studies of cultural competency. For more than two decades, such studies have appeared, albeit few in number and varying in methodological soundness. Studies included in their meta-analysis largely involved the comparison of culturally adapted mental health interventions to traditional mental health interventions. Griner & Smith (2006) identified 76 studies. Their analysis revealed a moderate effect size for culturally competent interventions [the random effects weighted average effect size was $d = 0.45$ ($SE = 0.04$, $p < 0.0001$), with a 95% confidence interval of $d = 0.36$ to $d = 0.53$. The data consisted of 72 nonzero effect sizes, of which 68 (94%) were positive and 4 (6%) were negative. Effect sizes ranged from $d = -0.48$ to $d = 2.7$].

Importantly, Griner & Smith (2006) attempted to control for or clarify the effects of other possible confounding variables.

- a. Publication bias (e.g., studies with statistically significant results are more likely to be published than are studies with statistically nonsignificant results). Their analysis indicated that publication bias does not appear to be a substantial threat to the results obtained in the meta-analysis.
- b. Participant characteristics (i.e., participant age, clinical status, gender, ethnicity, and level of acculturation). Older individuals had higher effect sizes than younger persons. In general, ethnicity of the client did not moderate the results obtained. In addition, for Hispanic clients, ethnicity tended to interact with acculturation in that low levels of acculturation appeared to profit greatly from culturally competent interventions.
- c. Research procedures (e.g., experimental versus single-group designs). Overall results were not altered by studies that varied as to the research design, inclusion of control groups, or nature of the control group.
- d. Type of cultural adaptations. Some studies involved individual therapy whereas many others involved group interventions or a combination of the two. The format of the

intervention did not moderate the overall results, nor did the duration of interventions. However, studies that were focused on one ethnic/racial population yielded higher effect sizes than those in which mixed racial populations were included. Studies in which there were no reports of attempting to match clients and therapists based on ethnicity had average effect sizes that were higher than those of studies in which ethnic matching was generally attempted (but not consistently conducted). Studies in which the client was matched with a therapist based on language (if other than English) had outcomes that were twice as effective as were studies that did not match language.

The contribution of Griner & Smith (2006) is highly significant. Not only do they provide evidence for the value of cultural competency, but they also examine possible confounding effects associated with cultural competency. As recognized by the investigators, their meta-analysis was the first one to be applied to cultural competency studies. Therefore, it included all research reports available, regardless of quality and rigor. Indeed, the reports varied considerably in terms of population studied (problems/disorders, age groups, ethnicity, etc.), methodology (random versus nonrandom assignment to treatment/control conditions, follow-up design, measures used, etc.), and type of treatment (e.g., from English translations of materials to contextual changes in the setting of treatment). Given the diversity of the studies, cultural competency has positive effects on treatment outcomes even though the precise factors that account for the effects cannot be easily specified at this time.

Three positions, ranging in favorability to cultural competency adaptations, have been articulated from reviews. First, Griner & Smith (2006) conclude in their meta-analysis that cultural competency interventions have a moderate positive effect. Second, Miranda et al. (2005) take a more cautious position because of the lack of adequate tests for cultural competency effects. Nevertheless, they state, "In the absence of efficacy studies, the combined use of protocols or guidelines that consider culture and context with evidence-based care is likely to facilitate engagement in treatment and probably to enhance outcomes." Third, in contrast to the conclusions of Smith & Griner (2006), Huey & Polo (2008) state in their meta-analysis:

... there is no compelling evidence as yet that these adaptations actually promote better clinical outcomes for ethnic minority youth. Overemphasizing the use of conceptually appealing but untested cultural modifications could inadvertently lead to inefficiencies in the conduct of treatment with ethnic minorities.

Thus, the most discrepant conclusions are derived from the two meta-analyses. The differing conclusions may simply be the result of the nature of the studies. Griner & Smith (2006) included interventions with adults and children, whereas Huey & Polo (2008) focused on children and youths. Interestingly, little overlap exists in the cultural competency adaptation studies that were included in their respective meta-analyses, even when one takes into account the dissimilar time periods for the reviews. This may reflect different inclusion/exclusion criteria used in the two meta-analyses. In addition, differences may exist in how the studies are interpreted. The relatively few rigorous studies that directly compare culturally adapted interventions with nonculturally adapted interventions also add to the problems in trying to draw conclusions. Two studies (Kohn et al. 2002, Miranda et al. 2003a) comparing culturally adapted CBT with nonculturally adapted CBT demonstrated the superiority of the cultural interventions. Finally, it is possible that interventions not considered culturally adapted may contain cultural features. As mentioned above, treatments may include discussions of cultural content even though they are not intended to be culturally adapted interventions. Or the treatments (e.g., CBT) may be inherently consistent with one's cultural orientation, as argued by Rossello et al. (2008). In either case, the manipulation of "not adapted" may be contaminated.

FINAL THOUGHTS

1. The preponderance of evidence shows that culturally adapted interventions provide benefit to intervention outcomes. This added value is more apparent in the research on adults than on children or youths. The additive effect of culturally adapted interventions is consistent with research examining the extent to which an intervention is implemented according to its original design, namely, its fidelity or is adapted. Blakely et al. (1987) found that adaptations involving adding certain features to an intervention were more effective than were adaptations involving replacing a component of the intervention.
2. Culturally competent interventions cover a whole range of activities (e.g., language match, discussions of cultural issues, and delivery of treatment in a culturally consistent manner).
3. Given the relatively few empirical studies of cultural competency, more research is needed, especially randomized clinical trials and “unpackaging” research that examines which cultural adaptations are effective.
4. Therapist, client, and intervention factors probably influence who is most likely to benefit from specific culturally adapted interventions. For example, cultural competency methods are probably more important with unacculturated than with acculturated ethnic minority clients. Individual differences as well as ethnic and cultural differences should be considered in the nature of the intervention delivery styles and content.
5. Little consensus currently exists as to when to use cultural interventions. Some believe that all interventions should be culturally competent in that therapists need to have appropriate cultural awareness, knowledge, and skills to work with clients. The kind-of-person model for cultural competency argues for cultural competency as an integral part of any treatment. For other multiculturalists, cultural interventions should be introduced under certain conditions. Leong & Lee (2006) have developed a model intended to identify cultural gaps in particular treatments and then to adopt adaptations that address the gaps. Lau (2006) maintains that culturally adapted treatments should be judiciously applied and are warranted (*a*) if evidence exists that a particular clinical problem encountered by a client emerges within a distinct set of risk and resilience factors in a given ethnic community or (*b*) if clients from a given ethnic community respond poorly to certain EBT approaches. In other words, cultural adaptations to EBT should be used if the problems encountered by individuals are influenced by membership in a particular (e.g., ethnic minority) community or if members of that community respond poorly to a standard EBT treatment. Similarly, Zavfert (2008) proposes that an ideographic approach should be taken that would rely on assessment of key cultural factors that are empirically determined to be most relevant to development and maintenance of a particular problem. When specifying culturally competent adaptations, the particular cultural factors affecting the client are considered as well as individual differences in acculturation, experiential background, type of disorder, etc.
6. A major disconnect appears to exist between cultural competency guidelines or recommendations and psychotherapy research examining cultural issues in treatment. The former has tended to focus on characteristics, values, attitudes, and skills on the part of the therapist that can minimize the social and cultural distance between care provider and client, whereas the latter has tended to examine changes in treatment procedures and content that more adequately address the cultural experiences of ethnic minority clients. This difference in emphasis on therapist adaptation as opposed to

treatment adaptation may partially account for the slow progress made in developing culturally competent mental health care. Norcross & Goldfried (1992) found that therapist and relationship factors accounted for 30% of the improvement in psychotherapy patients, whereas client, family, and other environmental factors accounted for 40%. Specific treatment techniques when combined with the expectancy factors commonly associated with placebo effects accounted for the other 30% of improvement. This research strongly suggests that both therapist and treatment adaptations warrant attention in cultural competency studies. Clearly, research is needed that investigates how these two types of adaptations interact and the separate and combined effects they have on treatment outcomes. For example, in most treatment adaptation studies, the level of therapist skill related to cultural competency is unknown or not assessed. On the other hand, when therapist cultural competency skills are examined, it is unclear if therapists who are deemed culturally competent also may be using certain cultural adaptations in their treatment practices. At the very least, these types of adaptations must be examined or controlled for if research on cultural competence is to proceed in a more informed manner.

7. Finally, the evaluation of the extent to which therapists and interventions effectively address cultural issues is situated in the complex interplay of processes that account for behavior and attitudinal change in psychotherapy. We have noted that theoretical and methodological inadequacies in psychotherapy research have combined to perpetuate imprecise models of change. When it is unclear how people change in psychotherapy and what they have learned in this process, the task of identifying those aspects of treatment that would make it culturally responsive or competent becomes even more difficult (Zane & Sue 1991).

SUMMARY POINTS

1. There is a growing movement to make services more culturally competent.
2. Cultural competency has been defined in many different ways, and it has provoked considerable controversy over its assumptions, effects, and necessity.
3. Cultural competency interventions have varied considerably, ranging from encompassing an entire treatment program to selected adaptations to existing treatment procedures.
4. Research on cultural competency has increased over time, although research designs have differed in the degree of rigor.
5. The available evidence indicates that cultural competency in psychological interventions and treatments is valuable and needed.

FUTURE ISSUES

Further research is needed to answer the following questions.

1. Is cultural competency better conceptualized as a concrete skill that can be learned by anyone or as a complex process that depends on social interactions?
2. Can a theoretical model be devised that explains cultural competency and why it works?
3. Why do research findings on the effects of culturally competent interventions show so much variability?
4. How can the multicultural guidelines adopted by the American Psychological Association be implemented in research, practice, and training?

5. Can universally beneficial treatment strategies (that apply to everyone) versus beneficial culture-specific interventions (that apply to specific populations) be identified?

Glossary

BSFT	brief structural family therapy
IPT	interpersonal psychotherapy
EBPs	evidence-based practices
ESTs	empirically supported treatments

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