# The Elusive Construct of Cultural Competence

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The origins of cultural competence as a construct are unclear. We have evidence as far back as 1927 of discussions regarding race and culture in psychology. Klineberg's (1927, 1934) pioneering work in intelligence testing debunked myths of racial superiority using scientific data and Kenneth and Mamie Clark's foundational experiments (Clark & Clark, 1939) were used to support school desegregation in the USA in 1954. In the 1950s, Madeleine Leininger began developing a theory of cultural care diversity and universality (Leininger, 1988). In 1967, Gordon Paul (1967) famously asked "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances," (p. 111) albeit outside of a discussion of culture, this question remains deeply relevant to psychotherapists advancing cultural competence today. In the 1970s, various conferences in psychology (Vail, Austin, Dulles conferences) professionals discussed the need for integrating multiculturalism into training (Gamst, Liang, & Der-Karabetian, 2011; Sue et al., 1982). The term itself increased in prominence in the scholarly literature in the 1990s (Saha, Beach, & Cooper, 2008).

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In the decades following, there has been much support for the concept of cultural competence (Gallardo, Parham, Trimble, & Yeh, 2012) especially related to health care delivery across applied professions (e.g., nursing, social work, psychology, medicine; Kohli, Huber, & Faul, 2010; Leininger, 1988; Loftin, Hartin, Branson, & Reyes, 2013; National Association of Social Workers, 2015). Among academics and practitioners in cultural competence, there is agreement that cultural considerations in treatment ought to *transform* practice rather than be an added consideration in practice (Gallardo et al., 2012; Leininger, 1988).

Professionals across helping professions appear to enthusiastically favor an approach to service provision, scholarship, and teaching that considers culture and context. How to define cultural competence and practice in accordance to guidelines for the advancement of cultural competence, however, appears to be a work in progress. In this chapter, we will focus on definitions of cultural competence and associated constructs in the context of helping professions. There is much work in other fields (e.g., education; McAllister & Irvine, 2000; National Education Association, 2017), however that work is beyond the scope of our discussion. We provide a table with definitions advanced across helping professions. We also report on efforts to train students and providers to improve cultural competence.



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## Definitions of Cultural Competence

Literature on cultural competence exists in multiple fields such as nursing, mental health, medicine, education, and social work (to name a few) with definitions and terminology varying from discipline to discipline. For example, social work was one of the first fields to examine the idea of "cultural awareness" as an important factor in service provision (Green, 1982). One of the earliest mentions of cultural competence as a framework for informing patient care in nursing is "cultural care theory," which is a holistic method of acknowledging cultural lifeways while providing patient services (Leininger, 1988). Leininger recognized that interactions between providers and patients were a process with multiple moving parts which required a certain sense of linkage to help unify exchanges.

In the field of mental health, cultural competence is generally conceptualized as a tripartite model composed of self-awareness, knowledge, and skills (Sue, Arredondo, & McDavis, 1992). Self-awareness refers to both attitudes that a person holds about cultural groups other than their own and awareness of themselves as cultural beings. Knowledge refers to specific knowledge about other cultural groups (e.g., language, traditions, beliefs). Skills refer to specific interpersonal and intervention abilities. This definition is one of the most frequently cited models in the literature (Bernhard et al., 2015), especially within psychology. Cultural competence is also frequently defined as a set of congruent behaviors that extend well beyond tolerance to allow professionals to work effectively in cross-cultural settings (Cross, Bazron, Dennis, & Isaacs, 1989; Roberts et al., 1990). While Sue et al.'s (1992) definition focuses on individual's abilities, Cross et al. (1989) focus on a "system of care" that includes individual as well as programs, agencies, and institutions.

Table 2.1 illustrates the evolution of definitions of cultural competence over time. While this table is not exhaustive, it is representative across helping professions. Existing definitions constitute a wide range from "the process of working with patients from a different cultural background than one's own" (Hadwiger, 1999, p. 47) to a more nuanced set of guidelines based on an ecological approach to cultural competence that reflect "current trends in the literature that consider contextual factors and intersectionality among and between reference group identities, including culture, language, gender, race, ethnicity, ability status, sexual orientation, age, gender identity, socioeconomic status, religion, spirituality, immigration status, education, and employment, among other variables" (American Psychological Association, 2002, 2017).

While social workers, nurses, physicians, and counselors may often represent a much needed "front line," cultural competence may be extended throughout service industries as it also pertains to the work of receptionists, administrative staff, human resources specialists, and CEOs. The notion that organizations must have the ability to incorporate cultural competence "in all aspects of policy making, administration, practice, service delivery and systematically involve consumers, key stakeholders and communities" has become more widely recognized (National Center for Cultural Competence, 1998). Through continued evolution of these concepts, cultural competence has been utilized from a systems perspective with multiple authors acknowledging the need for application of cultural competence in policy making and at multiple tiers of service-oriented organizations (Brach & Fraserirector, 2000). Some definitions of cultural competence have also included recognizing systemic forms of oppression (Schlesinger & Devore, 1995), social justice (Krentzman & Townsend, 2008), and health disparities (Capell, Veenstra, & Dean, 2007).

## Emerging Components of Cultural Competence

As the definition of cultural competence has expanded and become more refined, more terms have been developed. For example, authors often emphasize cultural competence as "demonstrated" or an ongoing "lifelong process" where the competent provider acts as a lifelong learner, able to put cultural competence into action while

**Table 2.1** Definitions of cultural competence

| Author(s)/(Year) | Definitions |
|---|---|
| Sue (1982) | "Sue defined **multicultural counseling competence** as an ongoing process that involves counselors' development of: (1) awareness of their own cultural values, biases, and position in established power structures and the impact of these on relationships with clients, (2) awareness of a client's world view, and (3) ability to develop and implement culturally appropriate interventions" (as cited in Boyle & Springer, 2001, pp. 55–56) |
| Green (1982) | "Green (1982) first defined **cultural competence** as the ability to conduct professional work in a way that is consistent with the expectations which members of a distinctive culture regard as appropriate among themselves. This definition emphasizes the trained worker's ability to adapt professional tasks and work styles to the cultural values and preferences of clients" (as cited in Boyle & Springer, 2001, p. 55) |
| Tripp-Reimer and Brink (1985) | "**Culture Brokerage** is essentially an act of translation in which messages, instructions and belief systems are manipulated and processed from one group to another. As a nursing intervention, Culture Brokerage involves the nurse's acting as a mediator between clients and members of orthodox health professions. Culture Brokerage may be used whenever there are separate culture groups and a need to establish links between them" (p. 352) |
| Leininger (1988) | "The **cultural care theory** is held to be the broadest and most wholistic guide to study human beings with their lifeways, cultural values and beliefs, symbols, material and nonmaterial forms, and living contexts" (p. 155) |
| Cross et al. (1989) | "**Cultural competence** is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. The word 'culture' is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates--at all levels--the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs" (p. 13) |
| Roberts et al. (1990) | "A multitude of terms have been used in the field to relate cultural issues to practice. Among these terms are cultural competence, cultural sensitivity, cultural diversity, cultural relevance and cultural awareness. We have chosen to encourage programs to employ the term '**cultural competence'** for several reasons. Competence implies more than beliefs, attitudes and tolerance, though it also includes them. Competence also implies skills which help to translate beliefs, attitudes and orientation into action and behavior within the context of daily interaction with families and children" (p. 4) |
| Borkan and Neher (1991) | Borkan and Neher introduce the Developmental Model of **Ethnosensitivity** to address issues that arise in utilizing standard [cross-cultural] curriculum with medical trainees who have "varying capacities both to accept cultural differences and to integrate cross-cultural tools" (p. 212). The model is described as consisting of seven developmental stages: fear, denial, superiority, minimization, relativism, empathy, and integration (p. 213) |
| Sue et al. (1992) | "… [**cross-cultural counseling competency**] characteristics (a) counselor awareness of own assumptions, values, and biases; (b) understanding the worldview of the culturally different client; and (c) developing appropriate intervention strategies and techniques would each be described as having three dimensions: (a) beliefs and attitudes, (b) knowledge, and (c) skills" (p. 481) |
| Schlesinger and Devore (1995) | "The term '**ethnic sensitive social work practice**' once introduced came to be used by social workers when referring in a broad, general sense to practice that is mindful of the effects of ethnic and minority group membership in social functioning and seeks to incorporate this understanding into practice. Used this way, the term is not limited to any single or particular definition or approach" (p. 33) |
| Lavizzo-Mourey and MacKenzie (1996b) | "…we conceptualize '**cultural competence**' as the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. But perhaps the most significant aspect of this concept is the inclusion and integration of three areas that are usually considered separately when they are considered at all" (p. 919) |

(continued)

**Table 2.1** (continued)

| Author(s)/(Year) | Definitions |
|---|---|
| Tervalon and Murray-Garcia (1998) | "…**cultural competence** in clinical practice is best defined not by a discrete endpoint but as a commitment and lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves (L. Brown, MPH, Oakland health advocate, personal communication, March 18, 1994)" (p. 118) |
| National Center for Cultural Competence (1998) | "**Cultural competence** requires that organizations: have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally." Organizations must "have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve." Organization must be able to "incorporate the above in all aspects of policy making, administration, practice, service delivery and systematically involve consumers, key stakeholders and communities." In summary, "cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum." (This framework is cited as adapted from Cross et al., 1989). |
| Orlandi (1998) | Orlandi suggests that cultural competence is "clearly multidimensional" and that "relevant aspects vary on a continuum from high to low" (p. 297). Orlandi proposes a **Cultural Sophistication Matrix** consisting of cognitive, affective, and skills dimensions as well as overall effect ranging across categories of culturally incompetent, culturally sensitive, and culturally competent (p. 297) |
| Campinha-Bacote (1999) | Campinha-Bacote conceptualizes **cultural competence** as consisting of five interdependent constructs: (1) cultural awareness, or the "deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients' cultures"; (2) cultural knowledge, or the "process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures"; (3) cultural skill, which is defined as "the ability to collect relevant cultural data regarding the clients' health histories and presenting problems as well as accurately performing a culturally specific physical assessment"; (4) cultural encounters, which are a "process which encourages health care providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds"; (5) cultural desire, or the "motivation of health care providers to 'want to' engage in the process of cultural competence" (pp. 204–205) |
| Resnicow et al. (1999) | "Cultural competence is the capacity of individuals to exercise interpersonal cultural sensitivity. Thus, culturally competent refers to practitioners, whereas culturally sensitive relates more to intervention materials and messages" (p. 11) |
| Kim-Godwin, Clarke, and Barton (2001) | "In the proposed Culturally Competent Community Care (CCCC) model, community-based care is viewed on a continuum from individual-focused health to whole community population-focused health and health care. Four dimensions of **cultural competence** are proposed. These dimensions are caring, cultural sensitivity, cultural knowledge, and cultural skills. Cultural competence involves not only caring, but cultural sensitivity, knowledge, and language ability" (p. 919) |
| Sue (2001) | "The MDCC [Multiple Dimensions of **Cultural Competence**] offers a conceptual framework for organizing three primary dimensions of multicultural competence: (a) specific racial/cultural group perspectives, (b) components of cultural competence, and (c) foci of cultural competence" (p. 791). Sue goes on to note the three components of cultural competence: belief/attitude, knowledge, and skill (p. 799) |
| Betancourt, Green, and Carrillo (2002) | "The field of '**cultural competence**' in health care has emerged in part to address the factors that may contribute to racial/ethnic disparities in health care. Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency" (p. 2) |

(continued)

**Table 2.1** (continued)

| Author(s)/(Year) | Definitions |
|---|---|
| Dunn (2002) | "What exactly is **cultural competence**? One way to answer this question is by stating what it is not. Cultural competence is not something that can be taught in traditional ways. It is not a technical skill that one can master such as learning how to take a blood pressure reading or read an electrocardiogram. It is not a problem-solving skill that one can develop, such as the ability to interpret clinical signs. It is not a communication technique that one can refine, such as 'active listening' or 'use of I messages'. Cultural competence, in fact, requires a fundamental change in the way people think about, understand, and interact with the world around them" (pp. 105–106) |
| Purnell (2002) | "**Cultural competence** is a process, not an endpoint (See figure 1 *in Purnell, p. 11*). One progresses (a) from unconscious incompetence (not being aware that one is lacking knowledge about another culture), (b) to conscious incompetence (being aware that one is lacking knowledge about another culture), (c) to conscious competence (learning about the client's culture, verifying generalizations about the client's culture, and providing culturally specific interventions), and finally (d) to unconscious competence (automatically providing culturally congruent care to clients of diverse cultures)" (p. 9) |
| Shiu-Thornton (2003) | "**Cultural competency** is a term most associated with the provision of direct services to underserved and hard-to reach ethnic, linguistic, or cultural populations. Initially, this was articulated as providing heath or mental health care and services in a manner culturally sensitive or culturally appropriate to ethnic minority populations who faced multiple barriers in accessing and using these services" (p. 1361) |
| Frusti et al. (2003) | "**Diversity competence** is defined as an individual's ability to respect each person's uniqueness" (p. 31) |
| Suh (2004) | Attributes of **cultural competence** include ability, openness, and flexibility. Antecedents or elements of cultural competence include the following domains: cognitive (awareness & knowledge), affective (sensitivity), behavioral (skills), and environmental (interaction/ encounter). Outcomes are discussed as "receiver-based variables, provider-based variables, and health outcome variables" (p. 98) |
| Beach et al. (2005) | "**Cultural competence** has been defined as 'the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences' (Cooper & Roter, 2002) by recognizing the importance of social and cultural influences on patients, considering how these factors interact, and devising interventions that take these issues into account" (Betancourt, Green, Carrillo, & Ananeh-Firempong II, 2003) |
| Giger et al. (2007) | "The first imperative of **cultural competence** is to be competent in one's own cultural heritage. After personal understanding comes respect and appreciation for the values and behaviors of others. Knowledge of cultural differences is essential if sensitivity and competence are to occur. Only when self-awareness combines with insight about others then true sensitivity can be demonstrated by individuals, health care systems, and communities" (p. 98) |
| Sue and Sue (2008) | "…**cultural competence** is an active, developmental, and ongoing process and that it is aspirational rather than achieved" (pp. 43–44) |
| Abbe, Gulick, and Herman (2008) | "**Cross-cultural competence** refers to the knowledge, skills, and affect/motivation that enable individuals to adapt effectively in cross-cultural environments. Cross-cultural competence is defined here as an individual capability that contributes to intercultural effectiveness regardless of the particular intersection of cultures" (p. 2) |
| Krentzman and Townsend (2008) | "This study uses a definition of **cultural competence** drawn from the Sue (1982, 1992) and the National Association of Social Workers (2001) models…In brief, both models concur that cultural competence means having the beliefs, knowledge, and skills necessary to work effectively with individuals different from one's self; that cultural competence includes all forms of difference; and that issues of social justice cannot be overlooked" (p. 8) |
| Fantini (2009) | "Stated another way, **intercultural competence** may be defined as complex abilities that are required to perform *effectively* and *appropriately* when interacting with others who are linguistically and culturally different from oneself. Whereas effective reflects the view of one's own performance in the target language-culture (LC2; i.e., an outsider's or 'etic' view), appropriate reflects how natives perceive such performance (i.e., an insider's or 'emic' view)" (p. 458) |
| Kirmayer (2012) | Kirmayer suggests that **cultural competence**, "needs to be critically assessed and re-thought to identify alternative models and metaphors that may better fit the needs of patients and providers working in specific health care settings across nations, regions and communities" (p. 150) |

(continued)

**Table 2.1** (continued)

| Author(s)/(Year) | Definitions |
|---|---|
| Garneau and Pepin (2015) | "The constructivist definition of **cultural competence** proposed in this article is intended to reflect global trends, not just the majority perspective. Hence, we define cultural competence as follows: A complex know-act grounded in critical reflection and action, which the health care professional draws upon to provide culturally safe, congruent, and effective care in partnership with individuals, families, and communities living health experiences, and which takes into account the social and political dimensions of care" (p. 12) |
| Bustamante, Skidmore, Nelson, and Jones (2016) | "This construct [**intercultural competence**] frequently is used as the basis for developing measures of attitudes, dispositions, values, beliefs, knowledge, and skills of professionals' approaches to the other or those who differ culturally from themselves. Cultural competence might best be defined as one's attitudes toward, knowledge about, and skills in interacting appropriately and effectively with diverse groups of people (Fantini, 2009; Sue & Sue, 2007)" (pp. 298–299) |
| American Psychological Association (APA) (2017) | "It is important to note that, for the purposes of the *Multicultural Guidelines*, **cultural competence** does not refer to a process that ends simply because the psychologist is deemed competent. Rather, cultural competence incorporates the role of cultural humility whereby cultural competence is considered a lifelong process of reflection and commitment (Hook & Watkins, 2015; Waters & Asbill, 2013)" (p. 8) |
| Henderson, Horne, Hills, and Kendall (2018) | "Many terms and definitions exist in the literature as to the concept and meaning of **cultural competence** (Fantini, 2009). For example, the National Health and Medical Research Council, Australia (NHMRC, 2006, p. 7), defines cultural competence as 'a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professions to work effectively in cross- cultural situations'. In this sense, cultural competence is the capacity of the health system to improve the health of consumers by integrating culture into the delivery of health services" (p. 591) |
| Benuto, Singer, Casas, González, and Ruork (2018) | "Cultural competency is best conceptualized as a two-dimensional construct whereby the dimensions of knowledge and awareness are a single dimension" (p. 379) |

incorporating new skills across multiple settings and situations (Lavizzo-Mourey & Mackenzie, 1996a; Tervalon & Murray-Garcia, 1998). Campinha-Bacote (1999) extended previous views of cultural competence to incorporate "cultural encounters" as a necessary component of building on cultural competence skills. Campinha-Bacote also added "cultural desire" as a means of gauging the investment of the professional in the competence process. In Table 2.2, we lay out some existing and emerging terms in the cultural competence literature.

We view the terms in Table 2.2 as emerging components of cultural competence and not as separate entities. For example, *cultural adaptation* of evidence-based interventions is related to *cultural competence* but is a distinct construct. Indeed, a recent meta-analysis provides evidence for both in the same manuscript (Soto, Smith, Griner, Domenech Rodríguez, & Bernal, 2018). Cultural adaptation refers to the efforts made to tailor a specific treatment, often a manual, whereas cultural competence refers to the skills of a person. A culturally competent provider may look for a cultural adapted treatment manual to support their intervention efforts.

In reference to the numerous ways in which cultural competence and other terms from the literature intersect, some common themes emerge. For instance, words such as "consideration," "acknowledgement," and "engagement" are frequently used across terminologies, denoting that competence regardless of discipline requires both a reflective and active component. Certainly, we cannot learn to be culturally attuned, responsive, or competent without first exploring or considering the histories and modern contexts in which an individual exists. Language and cultural identities are key components of this existence continuum, as are ways of knowing, being, and operating in a given environment (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Hoskins, 1999). As

**Table 2.2** Terms in cultural competence literature

| Term | Definition |
|---|---|
| Cultural adaptation | Cultural adaptation is "the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal et al. 2009, p. 362) |
| Cultural attunement | A relational process utilized when engaging in an interpersonal exchange and that involves "(a) acknowledging the pain of oppression, (b) engaging in acts of humility, (c) acting with reverence, (d) engaging in mutuality, and (e) maintaining a position of 'not knowing'." (Hoskins, 1999, p. 77) |
| Culturally based | "Refers to programs and messages that combine culture, history, and core values as a medium to motivate behavior change. Examples include Afrocentric substance use or violence prevention programs or programs for indigenous Americans that focus on ancestral spiritual systems… culturally based interventions, while potentially effective, have the potential to be culturally insensitive"… when it is assumed that "individuals identify with and gravitate toward their racial/ethnic group psychologically and socially" without checking that assumption (Resnicow et al. 1999, pp. 11–13) |
| Cultural humility | "Cultural humility incorporates a life-long commitment to self-evaluation and self-critique, to redressing power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-Garcia, 1998, p. 117)<br>"In a multicultural world where power imbalances exist, cultural humility is a process of openness, self awareness, being egoless, and incorporating self reflection and critique after willingly interacting with diverse individuals. The results of achieving cultural humility are mutual empowerment, respect, partnerships, optimal care, and lifelong learning." (Foronda, Baptiste, Reinholdt, & Ousman, 2016, p. 213)<br>Cultural humility is "self-reflective, other-oriented, and power-attenuating openness to clients as multicultural beings" (Tormala, Patel, Soukup, & Clarke, 2018, p. 54) |
| Cultural responsiveness | "Social workers need to appreciate the traditions and beliefs of clients from different cultures to provide effective services" (Yukl, 1986, p. 223); "It cannot be emphasized enough that the communication of an understanding and appreciation of [American Indian] cultural values is primary in establishing the desired therapeutic alliance with [American Indian] patients" (Yukl, 1986, p. 226) |
| Cultural safety | "In New Zealand during the 1980s the concept of cultural safety was born out of the work of a Maori nurse academic, Irihapiti Ramsden to address issues related to health disparities and unsafe interactions between the country's Indigenous and non-Indigenous peoples. More recently cultural safety has been viewed as a way forward and framework for non-Indigenous health professionals to work in partnership with Indigenous peoples to respond to the adverse impact of colonisation and help address significant health disparities (Williams, Smith, & Sharp, 2016). Cultural safety is underpinned by a social justice framework and requires individuals to undertake a process of personal reflection. Cultural awareness (defined as the beginning step in this process) acknowledges difference and contributes to cultural sensitivity (building on the awareness of difference through cultural acceptance, respect and understanding). Cultural safety is therefore a holistic and shared approach, where all individuals feel safe, can undertake learning together with dignity, and demonstrate deep listening (Ramsden, 2002; Wepa, 2003; Williams et al., 2016)" (Milne, Creedy, & West, 2016, pp. 20–21) |
| Cultural sensitivity | "The extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation or targeted health promotion materials and programs" (Resnicow et al., 1999, p. 11) |
| Cultural tailoring | "The process of creating culturally sensitive interventions, often involving the adaptation of existing materials and programs for racial/ethnic subpopulations" (Resnicow et al., 1999, p. 11) |
| Multicultural/cultural pluralism | "Incorporating and appreciating perspectives of multiple race/ethnic groups without assumptions of superiority or inferiority. In this sense, culturally competent individuals and culturally sensitive interventions are implicitly multicultural" (Resnicow et al., 1999, p. 11) |

(continued)

**Table 2.2** (continued)

| Term | Definition |
|---|---|
| Patient centered care | "The primary aim of patient centeredness has been to individualize quality, to complement the healthcare quality movement's focus on process measures and performance benchmarks with a return to emphasis on personal relationships and 'customer service'. As such, patient centeredness aims to elevate quality for all patients. The primary aim of the cultural competence movement has been to balance quality, to improve equity and reduce disparities by specifically improving care for people of color and other disadvantaged populations. Because of these different emphases, patient centeredness and cultural competence have targeted different aspects of healthcare delivery. Despite these different focuses, however, there is substantial overlap in how patient centeredness and cultural competence are operationalized, and consequently in what they have the potential to achieve" (Saha et al., 2008, p. 1282) |

an added layer of complexity, we live in a multicultural world and cultures interact. Hence the aforementioned components may vary from setting to setting (e.g., differ from the emergency room to a therapy session) or manifest quite differently in the presence of service providers of varying demographic characteristics (e.g., a patient seeing a doctor of similar or dissimilar race, ethnicity, age, sexual identity).

The idea of "considering," while one of the most frequently used descriptors in cultural competence frameworks, can be troublesome. By way of interpretation, "considering" may run the gamut from mild curiosity to in-depth examination. Likewise, "acknowledgement" is also a multifaceted component that requires personal introspection as to definition. Service providers may define acknowledgement as synonymous with recognition, equate the term with tolerance, or define it as acceptance. "Engagement" is equally ambiguous—Is the engagement process passive or active? Is "engagement" an agreement or a commitment? We would posit that the culturally competent provider is capable of taking a deeper dive into context, of moving beyond simple recognition, and be able to commit to actively becoming a part of the competence process. Reflection and action become mechanisms through which cultural competence is conducted and with them comes a certain awareness on the part of the service provider, which maybe unpleasant or even painful depending on the insights gained. We think this further demonstrates that the terms in Table 2.2 are facets of the same cultural competence paradigm, each having specific utility within their own service frameworks. This is not to discount the importance of these diverging terms. The spirit in which these frameworks operate is the same one personified by true cultural competence wherein providers may hold varied perspectives together to arrive at a more comprehensive understanding. Regardless, a unified definition is certainly lacking despite "increased attention to understanding," and practitioners and researchers generally agree there is a distinct need for a clearer conceptualization of cultural competence (Boyle & Springer, 2001; Roberts et al., 1990; Worthington, Soth-McNett, & Moreno, 2007).

## Competencies and Benchmarks

Cultural competence training has evolved based on the available definitions and conceptualizations. Older publications point to frameworks. For example, Cross et al.'s (1989) continuum for understanding a provider or agency's location on the cultural competence spectrum that ranges from culturally destructive to culturally proficient. For each of the six levels, Cross provides attitudinal and behavioral descriptors. Sue et al. (1982) provided the first benchmarks for cultural competence from the American Psychological Association's Division 17 Education and Training Committee for clinicians. Currently, individual and cultural diversity are considered one of the foundational competencies for psychologists and the behavioral anchors for the benchmarks include knowledge of self and others as cultural beings and applies to interactions, assessment,

treatment, and consultation (Fouad et al., 2009; Hatcher et al., 2013).

Standards for accreditation for Medical Education include cultural competence and health care disparities based on the tripartite model, including self-awareness, knowledge, and skills (Liaison Committee on Medical Education, 2018). Medical professionals must acknowledge "[t]he manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments" (p. 11) and the standard goes further to include the need to recognize and address health care disparities (Liaison Committee on Medical Education, 2018). Medical educators developed benchmarks for faculty in medical schools (Sorensen et al., 2017) and evaluated them empirically to derive ten critical characteristics of cultural competence needed to effectively train medical students (Hordijk et al., 2019).

In the field of social work, the emphasis on cultural competence is interwoven into many facets of the profession. The *Code of Ethics of the National Association of Social Workers* begins by stating "[t]he primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (National Association of Social Workers, 2017). Principles in the ethics code highlight the importance of diversity and cultural competence is a prominent ethical standard. One of the nine educational accreditation competencies in social work is to "Engage Diversity and Difference in Practice" (Council on Social Work Education, 2015). The professional practice guidelines in social work further expand the reach of cultural competence in that it

> also requires advocacy and activism. It is critically important to provide quality services to those who find themselves marginalized; and it is also essential to disrupt the societal processes that marginalize populations. Cultural competence includes action to challenge institutional and structural oppression and the accompanying feelings of privilege and internalized oppression (National Association of Social Workers, 2015, p. 10).

The importance of cultural competence for helping professionals in the field has become more evident with multiple professional organizations adopting and tailoring specific guidelines of cultural competence to facilitate education and training of professionals in response to the increasing diversity of patients, clients, and students (Boyle & Springer, 2001; Frusti, Niesen, & Campion, 2003). Elements of cultural competence can be found throughout the American Counseling Association's code of ethics (American Counseling Association, 2014) and in many different practice competencies, such as *Competencies for Counseling the Multiracial Population* (Multi-Racial/Ethnic Counseling Concerns (MRECC) Interest Network of the American Counseling Association Taskforce & Counseling Association Taskforce, 2015), *Multicultural and Social Justice Counseling Competencies* (The Multicultural Counseling Competencies Revisions Committee, 2015), in addition to competency guidelines for specific populations. Psychology professionals can look to the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change* (American Psychological Association, 2017) as well as guidelines for specific populations, such as *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* (American Psychological Association, 2015).

## Summary and Recommendations

Rather than seeing the definition of cultural competence as a moving target, we understand that the definitions of both "culture" and "competence" are elusive in nature and, thus, a definition of cultural competence is necessarily a work in progress. As we culled through the literature, we see many terms and we welcome them, and we also know that sometimes narratives are more directed at replacing rather than enriching bodies of scholarship. One of our overarching recommendations is for scholars and practitioners to embrace the complexity of this construct and resist the urge to find a replacement construct with a neat definition but rather incorporate new

knowledge and conceptualizations as they arise and celebrate the deeper and broader understanding that results from added concepts.

Researchers may feel the most desire to have a working operational definition, especially in consideration of measurement. Existing measures are usually based on different components of cultural competence, including the tripartite components (e.g., Revised Multicultural Awareness, Knowledge, & Skills Survey, Counselor Edition: Kim, Cartwright, Asay, & D'Andrea, 2003; Multicultural Counseling Self-Efficacy Scale, Racial Diversity Form: Sheu & Lent, 2007; Sheu, Rigali-Oiler, & Lent, 2012). The aforementioned scales, as most measures of cultural competence, are practitioner self-report and can serve to facilitate self-awareness and reflection. There are also measures of supervisor ratings of trainees cultural competence (LaFromboise, Coleman, & Hernandez, 1991), trainees' and supervisors' perspectives of multicultural competence in supervision (Pope-Davis, Toporek, & Ortega-Villalobos, 2003), student ratings of professional programs' training and curriculum in regards to multicultural climate (Pope-Davis, Liu, Nevitt, & Toporek, 2000), and client perceptions of helping professionals' cultural competence (Cornelius, Booker, Arthur, Reeves, & Morgan, 2004). These measures are not a criterion style measure as there is not a cut-off score and thus one possesses cultural competence, but these measures allow for room to grow in cultural competence.

A criticism of cultural competence is that the term somehow communicated that one is to possess said competence. In fact, cultural competence has been operationally defined as a journey, not a destination, from early inceptions (Cross et al., 1989; Sue et al., 1982). When introducing the concept of cultural humility, Tervalon and Murray-Garcia (1998) did not suggest it as a replacement term but rather recommended that cultural humility might be a more realistic achievement for medical trainees receiving cultural competence training given the definition of cultural competence they espoused which was "a commitment and active engagement in a lifelong process that individuals enter into an ongoing basis with patients, communities, colleagues, and themselves"(p. 118). Their working definition was similar to Cross et al. (1989):

> Becoming culturally competent is a developmental process for the individual and for the system. It is not something that happens because one reads a book, or attends a workshop, or happens to be a member of a minority group. It is a process born of a commitment to provide quality services to all and a willingness to risk. (p. 21)

Similarly, Resnicow, Baranowski, Ahluwalia, and Braithwaite (1999) clarify that cultural competence is the ability to exercise cultural sensitivity in an interpersonal exchange. The authors provide an important distinction that cultural competence resides in practitioners whereas cultural sensitivity resides in materials and messages. Domenech Rodríguez and Bernal (2012) make a similar distinction between cultural competence which resides in the practitioner, and cultural adaptations, which reside in the treatment manuals.

We do understand the practical concerns that have led to a desire to have an agreed upon definition so that interventions may be developed for trainees or helping professionals, which in turn would allow for their test of effectiveness for both learning of providers and the outcomes of those whom they serve. We do believe the literature shows a great deal of diversity in conceptualizations, and also points fairly clearly to agreement over the use of the tripartite model of cultural competence as a primary conceptualization. For providers that want clear guidance, it would be reasonable to proceed with that model (Sue et al., 1992; Sue, 1998).

In sum, a great deal of thought and consideration has gone into understanding the importance of culture in interpersonal exchanges as they relate to outcomes in psychotherapy and other helping professions. We believe the elusive nature of the construct of cultural competence is perhaps due to the very nature of cultural competence as a complex and multi-faceted one. Rather than consider the construct as elusive or problematic, we believe the work is still in progress. However, practitioners, educators, researchers, administrators, and other stakeholders cannot necessarily wait until a definition is perfectly

operationally defined and measurable. We recommend proceeding with caution, while actively pursuing self-awareness, knowledge of cultural others, and specific skills. We are particularly fond of scientific mindedness and dynamic sizing as important guidelines for specific behavior. We would challenge mental health professionals to expand the notion of scientific mindedness and dynamic sizing to include efforts outside of themselves and include consultation with other professionals. The process by which each professional pursues cultural competence, is itself a marker of this so-called elusive trait.

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