3 History and Development of Cultural Competence Evaluation in Applied Psychology

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The history and development of cultural competence (CC) research and advocacy have advanced to the point where, at the time of this writing, it is a ubiquitous concept that is aggressively promoted by the federal government; professional groups representing various branches of applied psychology, social work, healthcare, education, and business; academic/training institutions and their accrediting bodies; state/national boards that license and certify applied psychologists; as well as the agencies that employ psychologists and counselors who deliver mental health services to the general public (see previous chapter). As a result, publications on the topic assume implicitly that the existence, validity, and benefits of cultural competence are "settled law", and that the issue of pressing concern is how to train practitioners to "get it" and subsequently deliver its benefits more efficiently and effectively to the general public.

This chapter covers the history and development of a parallel movement in applied psychology that has seriously questioned many of the implicit and explicit assumptions that support cultural competence theory and advocacy. These criticisms originate from sources both within applied psychology and from various sources outside of applied psychology. These criticisms of CC can be broadly subdivided into two somewhat correlated categories: (1) criticisms that question and/or call into doubt the fundamental construct validity of the CC concept and (2) criticisms based on assumptions that fundamentally support the construct validity of CC, but are offered as a means for improving its conceptualization, measurement, and/or application.

Criticisms that Undermine Cultural Competence (CC) Theory/Advocacy

A construct can be defined as a skill, attribute, or ability that is based on one or more established theories (Study.com, 2017; see also Slaney, 2017, for a more in-depth discussion and analysis). The concept of "construct validity" has traditionally been discussed within psychology as an attribute of a test or assessment instrument in measuring entities that are largely unobservable (Smith, 2005). In the context of this chapter, construct validity refers to the extent to which cultural competence is clearly articulated in theory, as well as reliably observed to exist in real-life practice.

A number of critics have described numerous shortcomings of CC theory and advocacy that are so fundamental as to cast doubt on its construct validity. These criticisms can be categorized as originating from semantic, logical/conceptual, empirical, philosophical, pedagogical, and professional best practices perspectives - each of which are briefly described below.

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Semantic Critiques

Critiques within this category essentially argue that key words and phrases frequently used in CC advocacy are poorly and/or inaccurately defined when examined closely. When this happens, words function as euphemisms instead of as direct referents, communication lacks clarity, and the use of poorly defined terms distorts an accurate picture of conditions as they actually occur in the "real world."

Culture/Cultural Differences The word "cultural" functions as an adjective that modifies the noun "competence." There is a general agreement among social science historians that the root word "culture" (and its derivatives) is arguably one of the most difficult terms to define with precision. Kroeber and Kluckhohn (1952) compiled approximately 150 working definitions of culture found in a variety of disciplines up to publication of their book. Four decades later, Baldwin and Lindsley (1994) published a compilation of 200 definitions of culture. A little over two decades later, Baldwin, Faulkner, Hecht, and Lindsley (2006) published a list of more than 300 definitions of culture.

These compilations highlight four important observations: First, the serious study of culture occurs within sub-disciplines whose primary focus is in understanding the dynamics of the culture concept (cultural anthropology, cultural sociology, cultural psychology). Second, culture is an *extremely* difficult concept to define. As quoted in Trimble (2007):

> Although people may be able to achieve a modicum of consensus on what culture is in general, the agreement seems to fall apart when scholars attempt to break down its meaning into some reasonably well-defined components … the [culture] construct often is used too casually for descriptions of the human condition … "culture" is a summary label, a catchword for all limits of behavioral differences between groups, but within itself [has] virtually no explanatory value. (p. 248)

Trimble (2007) then proceeds to quote Geertz (2000), who in turn writes:

> [T]he trouble is that no one is quite sure what culture is. Not only is it an essentially contested concept … it is fugitive, unsteady, encyclopedic, and normatively charged, and there are those … who think it vacuous altogether, or even dangerous, and would ban it from the serious discourse of serious persons. (p. 11, as quoted from Trimble, 2007, p. 248)

Third, among serious culture theorists, "culture" is not so much viewed as a static, unalterable entity needing to be accurately captured by any one definition. Rather, culture is viewed as a constantly evolving and fluid entity which requires definitions to adaptively shift over time in concert with emerging developments in particular disciplines. Although some sources within applied psychology candidly acknowledge that precise definitions of "culture" will always be elusive (see US Department of Health and Human Services, 2001, p. 7), it is *de rigueur* for applied social science publications to portray culture as being captured by a static definition to which practitioners must adhere (e.g., see American Psychiatric Association, 2013; American Psychological Association, 2003; Schim & Doorenbos, 2010). Fourth, since contemporary culture definitions must incorporate insights from the accumulation of decades of study on culture, proffered definitions tend to be highly abstract. As examples:

- "Cultures … are not material phenomena; they are cognitive organizations of material phenomena" (Tyler, 1976, p. 177).
- "One useful way to think about culture is to think of unstated assumptions, standard operating procedures, ways of doing things that have been internalized to such an extent that people do not argue about them" (Triandis, 1994, p. 16).
- "By approaching culture through the use of the idea of hegemony, culture can be conceptualized as a space within which struggles between social forces are conducted" (Smith, 2000, p. 81).

In contrast, "culture" has a considerably more simplified and concrete meaning when used in contemporary applied psychology, generally, and in the cultural competence movement, specifically. For all practical purposes, "culture" simply serves as an easy euphemism for racial, ethnic, or language group membership. By extension, the

term "cultural differences" functions as a softer and much more gentle phrase that is popularly used to connote simple differences in racial, ethnic, or language group membership.

Although such concrete connotations may make communication easier within applied psychology, many have argued that this does not accurately reflect the complexities of everyday American life (e.g., see Naylor, 1998; Wood, 2003). On this point, Triandis (2007) writes:

> Attributes such as nationality, religion, race, or occupation are not appropriate criteria for defining cultures. The use of a single criterion is likely to lead to confusion, as would happen if all people who eat pizza were placed in one category. Culture is a complex whole, and it is best to use many criteria to discriminate between one culture and another. (p. 65)

Stuart (2004) argues this point looking through a developmental lens, in which he writes:

> Parenting is the ultimate form of socialization, through which children learn how to function in society. But parents vary in their ability and desire to transmit cultural beliefs to their children, and children are not passive recipients of their parents' values and practices. This explains the fact that the culture with which young adults leave their families of origin is rarely a carbon copy of parental beliefs, making for a diversity of characters at every family reunion. (p. 4)

This quote points to the truism that cultural differences are *multidimensional, not unidimensional*, a point that is acknowledged – at least in passing – by most cultural competence advocates. Frisby (2005b) argues that it is more accurate to acknowledge that two or more persons can be culturally similar (according to one set of criteria) and culturally different (according to another set of criteria) *at the same time*, depending on which criteria are under consideration. As an illustration, Hispanic and Anglo comrades who are childhood friends growing up in the same city neighborhood may be "culturally different" with respect to their ethnic group membership, yet be "culturally similar" when it comes to their formative neighborhood socialization experiences. As a result, the notion that persons A and B are "culturally different" *in all areas* – simply because they belong to two different racial or ethnic groups – is a gross oversimplification of complex reality (see Frisby, 1996). Stuart (2004) writes:

> …[E]very individual is a unique blend of many influences. Whereas culture helps to regulate social life, specific beliefs are products of individuals' minds. Because of this complexity, it is *never* safe to infer a person's cultural orientation from knowledge of any group to which he or she is believed to belong.

It has become *de rigueur* for cultural competence articles, chapters, and books to assert as a fundamental principle that "everybody has a culture," "we are all multicultural beings," or similar variations on this idea (e.g., see American Psychological Association, 2003, p. 382; Ratts & Pedersen, 2014, p. 13). Many writers who are faced with the task of defining "culture" discover quickly that many variables other than race are implied by the concept. As an example, the APA Task Force on Evidence-Based Practice (2006) defines "culture" as follows:

> Culture, in this context, is understood to encompass a broad array of phenomena (e.g., shared values, history, knowledge, rituals, customs) that often result in a shared sense of identity. Racial and ethnic groups may have a shared culture, but those personal characteristics are not the only characteristics that define cultural groups (e.g., deaf culture, inner-city culture). Culture is a multifaceted construct, and cultural factors cannot be understood in isolation from social, class, and personal characteristics that make each patient unique. (p. 278)

This "tension" between the need to provide a concise definition of culture – balanced against the need to encompass all of its complex attributes – creates a definitional conundrum. When culture is then defined so broadly as to encompass everything, then it comes to mean nothing.

Competence As a noun, "competence" can be defined as the ability to do something well, successfully, or efficiently. It is the quality or state of being functionally adequate or capable, as when an individual possesses sufficient knowledge or skill to carry out a task or to do one's job (https://www.merriam-webster.com/dictionary/competence). Synonyms for competence include "capability," "facility," "prowess," "skill," "effectiveness,"

"fitness," "usefulness," or "talent." Antonyms for competence include "disability," "inability," "ineptitude," "impotence," or "inadequacy" (https://www.merriam-webster.com/thesaurus/competence).

Frisby (2009, p. 867, adapted from Jensen, 1992) argues that in order to objectively measure competence within any area, eight conditions must be met: First, the construct to be measured must involve *observable units of behavior* that results in some type of product (i.e., something spoken, written, created, or acted out). If a construct does not manifest itself with something that can be observed, then by implication it cannot be measured. Thus, unobservable constructs such as "attitudes," "knowledge," "dispositions," "sensitivities," and "awareness" do not meet this criterion (unless they result in observable products, behaviors, or verbalizations). Second, the behavior to be measured must be intentional, as opposed to an involuntary reflex. Third, there must be a high degree of agreement among different observers that the behavior of interest has occurred. Fourth, the units of behavior must be classifiable (e.g., judged as poor, fair, or excellent) or quantifiable in terms of a clear standard (e.g., solving 90% of math problems on a worksheet, putting a puzzle together within a given time limit). Fifth, there must be a high degree of agreement among different observers in judging the quality of the behavior. Sixth, the behaviors to be measured must be clearly demonstrated across fairly fixed conditions for all respondents, so that individual differences in performance can be attributed to differences in skill level rather than to differences inherent within the conditions of measurement/observation. Seventh, the units of behavior must demonstrate some degree of consistency and temporal stability (as opposed to displaying random patterns), so that mastery can be inferred.

These previous two criteria would be particularly difficult to meet given the almost infinite variation in the combination of client characteristics (e.g., age, gender, personality type, disability, personal history); the nature of clients' presenting problems, external factors influencing conditions for counseling/therapy (e.g., school-related vs. daily living problems, court-ordered vs. voluntary counseling, group vs. individual counseling); or the length of counseling/therapy (e.g., brief therapy spanning a few sessions vs. extended therapy spanning years). In short, the conditions under which mastery is inferred must be standardized to some degree. Eighth, consistency must be displayed across similar classes of observable behaviors, in order to infer a generalized ability.

According to Frisby (2009), there exist no published measures or clinical observation protocols that would enable psychologists to reliably evaluate a person's cultural competence in cross-cultural situations according to all eight of these criteria. Thus, when "culture" and "competence" are combined and the definitional challenges of both words are taken seriously, then a compelling case can be made that efforts to clearly understand the meaning of the phrase "cultural competence" are akin to trying to grasp smoke. This perception is echoed by Kleinman and Benson (2006), who write:

> Cultural competency has become a fashionable term for clinicians and researchers. Yet no one can define this term precisely enough to operationalize it in clinical training and best practices (p. 1673).

Some describe cultural competency as an ethereal entity that one is always pursuing but can never be fully attained. According to the Center for Substance Abuse Treatment (2014), "Gaining cultural competence, like any important counseling skill, is an ongoing process that is never completed; such skills cannot be taught in any single book or training session" (p. 2). For additional commentary on the difficulty of defining cultural competence, readers are encouraged to consult DeAngelis (2015) and Grant, Parry, and Guerin (2013).

Logical/Conceptual Critiques

Critiques within this category identify logical problems, conceptual problems, or a combination of both in the quality of the reasoning used to support cultural competence advocacy. Logical critiques draw from the principles of formal and informal logic (Bennett, 2015; McInerny, 2004) to find cultural competence arguments to be disingenuous, illogical, or invalid. Justification for

cultural competence advocacy and training has also been critiqued on the basis of its lack of conceptual clarity. This occurs when arguments use vague and/or ill-defined concepts or fail to provide strong and/or persuasive reasons to believe the conclusions.

Narratives are the raw material of the cultural competence movement to which a logical examination can be applied. In science, knowledge claims are established through data gathering, observation, measurement, statistical analysis, replication, and independent verification (Chang, 2014). In contrast, narratives are stories that function as a "received wisdom," which (either intentionally or unintentionally) circumvents the need for objective, independent research. Narratives provide audiences with predigested answers that determine what does or does not constitute a problem, what problems are perceived as more or less important, or how issues are interpreted and framed. The ultimate purpose for narratives is to persuade audiences to think a certain way, believe in certain ideas, develop an attitude for or against something, or motivate action on behalf of an issue.

Braden and Shah (2005) review and evaluate "multicultural training" (which for all practical purposes is synonymous with cultural competence training) research in school psychology by first stating the three fundamental mini-narratives that undergird this movement. These are:

1. Students from diverse racial, ethnic, or linguistic backgrounds in the United States have specialized educational and psychological needs that in turn require school psychologists to develop multicultural competencies.
2. Most educational problems of minority students can be ultimately attributed to an inability to understand cultural differences (i.e., cultural insensitivity) on the part of European American clinicians. Therefore, students and families of color should be served by psychologists of the same racial and ethnic backgrounds so they feel most comfortable and can achieve maximum success.
3. The evidence supporting the necessity of multicultural training and services is uncontestable; those who question its value are motivated to do so by racism.

Examining Unstated Assumptions An important skill in thinking logically and critically is to examine arguments for the presence of assumptions that are implicit in the argument but are not explicitly stated (Brookfield, 2012). A large part of what causes narratives to be problematic are the unstated assumptions that, when exposed and evaluated, deflate the persuasiveness of the narrative (e.g., see Kumaş-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). In the previous section, the persuasiveness of the first Braden and Shah (2005) narrative rests on the assumption that individuals from groups that differ racially and/or ethnically necessarily require different treatments in order to be effectively served (called the *Difference Doctrine*; see Frisby, 2013, pp. 18–9, 498–99). Frisby (2013) showed that (with the exception of interventions requiring non-English language modifications) school districts serving racially/ethnically diverse populations implement effective, "common sense" solutions to psychoeducational problems that have little or nothing at all in common with "multicultural" theories popularly espoused in academia.

The unstated assumption that undergirds Braden and Shah's (2005) second narrative is that problems disproportionately experienced by racial/ethnic groups must necessarily have "racial/ethnic" causes. However, Gottfredson (2004, 2005) reviews persuasive evidence suggesting that individual and group differences in general cognitive ability better explain most (but not all) difficulties faced by racial/ethnic minority groups in healthcare and education.

The assumption that undergirds Braden and Shah's (2005) third narrative is already explicit – namely, that empirical evidence irrefutably supports the validity and benefits of cultural competence – and thus any criticism of CC advocacy must stem from sinister and/or nefarious motives. Problems in the empirical soundness of

CC advocacy and research are addressed in greater detail in the next section (empirical critiques).

Frisby (2009) stated five implicit assumptions of the cultural competence movement in school psychology and then cited counterarguments for each that challenges their validity. The first implicit assumption is that *cultural differences between groups are inherently problematic for schools*. Frisby (2009) observes that some school settings experience serious problems resulting from racial/ethnic diversity, while other settings do not. He argues that the factors that influence the degree to which cultural differences pose problems for particular school settings are multifaceted, complex, and "setting-specific." These complexities and subtle nuances are completely ignored in light of aggressive advocacy in support of universal cultural competence training for all school psychologists.

A second implicit assumption is that *the nation's increasing diversity impacts all American schools, generally, and all school psychologists, specifically, in a uniform manner*. Most if not all books, book chapters, and articles written in support of cultural competency begin with a recitation of statistics documenting American's increasing racial/ethnic diversity (see "*History and Development of Cultural Competence Advocacy in Applied Psychology*" Chap. 1, this book). Frisby (2009) observes that the degree of cultural heterogeneity within America varies widely as a function of equally wide geographical differences among school settings and that racial/ethnic diversity per se has always been a common feature of American schooling throughout history (which begs the question as to why racial/ethnic diversity is popularly framed as a "serious problem" needing cultural competence training as a "solution").

A third implicit assumption is that *disproportionalities in social and educational problems among culturally diverse groups must have "cultural" explanations and "cultural" remedies*. Contrary to this assumption, it is IQ, not culture, which is the most powerful correlate of individual and group differences in school achievement outcomes (see Frisby, 2013, chapter 5). In addition, this assumption fails to explain why smaller subgroups within broad racial/ethnic groups experience different mean levels of academic achievement, or why students belonging to the same racial group experience different levels of academic achievement as a function of differences in schooling contexts (Frisby, 2009).

A fourth implicit assumption can be stated as follows: *Whatever school psychologists are doing currently in response to cultural diversity, it is inadequate for meeting the needs of culturally diverse groups absent specialized training in cultural competence*. Frisby (2009) cites research showing that school psychologists who deliver "traditional" assessment and special education decision-making services to children from racial/ethnic minority groups do not result in biased referral decisions, biased diagnostic/placement decisions, or biased assessments of cognitive test session behavior.

The fifth implicit assumption is that *there is a direct relationship between cultural competence and improved outcomes for culturally different clients in life*. This is the most central justification for CC training in all of applied psychology, yet it is the one assumption for which empirical evidence is virtually nonexistent (see section on Empirical Criticisms). Frisby (2009) argues that there are many complex factors that influence client outcomes in schools, the implication being that establishing the cultural competence/client outcome link is considerably challenging.

Syllogistic Reasoning One of the ways in which narratives can be evaluated for their logical soundness is to reduce their arguments into simpler syllogisms whenever possible. A syllogism consists of two brief premises (sometimes called a major and a minor premise), followed by a conclusion. One type of syllogism is the categorical syllogism, which has the following form:

(Major premise)	All A are B.
(Minor premise)	X is an A.
(Conclusion)	Therefore, X is a B.

Consider the statement "all racial and ethnic minority groups in the United States share experiences of oppression as a result of living in the

dominant White American culture" (Sodowsky, Kuo-Jackson, & Loya, 1997, p. 13). From this major premise, a categorical syllogism can be derived, the conclusion from which harmonizes with numerous texts and articles for training in cultural competence (e.g., see D'Andrea & Daniels, 2001; Ridley, 2005; Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006):

(Major premise)	All US racial and ethnic minority groups experience oppression.
(Minor premise)	My counseling client is a member of an American racial/ethnic minority group.
(Conclusion)	Therefore, my counseling client has experienced oppression.

One way to evaluate the truth claim of this syllogism is to examine the content of the major premise, which can be shown to suffer from a variety of problems. First, clear communication requires that the term *oppression* be carefully defined, which represents a principle discussed in the previous section. Is oppression as used here comparable to the oppression experienced by the "untouchable" Dalit peoples of India, who are treated as practically subhuman, having their marriage and occupational choices rigidly dictated by their caste membership (Mogul, 2016), who are regularly denied access to basic healthcare and nutritional services, or whose children are not allowed to touch the meals of children from other castes in the state schools in some regions (Jadhav, 2005; Sarkar, 2014)? Is oppression as used here also comparable to how women are treated in some Muslim countries, which observe strict rules related to what women wear, their social relationships with men, how they are to act in public, and how far they can advance occupationally (Ali, 2015; Lichter, 2009)? If not, then does the occasional microaggression (see Sue, 2010) qualify as an American "oppression" that is equivalent with these other examples?

Second, this premise can be challenged on the grounds of being too broadly stated, in that there exists no study which documents the presumed oppression of every last human being belonging to a particular racial/ethnic group. Although one can conceivably find historical writings which document oppression (however defined) visited on nearly all racial/ethnic groups in the United States *in a general sense*, it does not logically follow that *all individuals* within a group have experienced the same degree of oppression, if they have experienced oppression at all.

Many writers have identified the logical problems that result from making inferences about individuals from knowledge of broad groups. Frisby (2005a, 2005b, 2013) calls this the "Group Identity Doctrine." Dreher and MacNaughton (2002) call this the "ecologic fallacy." Stuart (2004) calls this the logical flaw of "basing ideographic predictions on nomothetic data sets" (p. 5).

A second type of syllogism found in arguments is the propositional "if/then" syllogism, which is subject to a logical error called "affirming the consequent" (Bennett, 2015). The symbolic form of this logical error is given below:

(Major premise)	If A, then B
(Minor premise)	B
(Conclusion)	Therefore, A

The fallacy here lies in the assumption that the presence of B necessarily means the presence of A as the causal factor. Even though A leads to B, there could be numerous reasons that have nothing at all to do with A that could be responsible for the presence of B. This logical error can be brought into sharper focus with a simple example:

(Major premise)	All cats have fur.
(Minor premise)	This animal has fur.
(Conclusion)	Therefore, this animal is a cat.

Some critics have observed that cultural competence advocacy is built on this logical error, the syllogistic form for which is given below:

(Major premise)	The cultural competence of caregivers leads to positive outcomes for culturally diverse clients.
(Minor premise)	This culturally diverse client experienced a positive outcome.
(Conclusion)	Therefore, the caregiver was culturally competent.

The converse is also present in cultural competency advocacy:

(Major premise)	The lack of cultural competence in caregivers leads to negative outcomes for culturally diverse clients.
(Minor premise)	This culturally diverse client experienced a negative outcome.
(Conclusion)	Therefore, the caregiver lacked cultural competence.

It should be noted at the outset that the major premise in the positive and negative forms of these syllogisms assumes implicitly that cultural competence is an empirically validated construct that can be reliably measured (an issue that is discussed in subsequent sections of this chapter). Separate from this issue, however, is the issue of whether or not the conclusions are logically warranted.

In evaluating the cultural competence movement in school psychology, Frisby (2009) observes that many reasons exist for the success or failure of interventions for minority clients within schools that have nothing at all to do with the presence or lack of school psychologists' cultural competence (however defined). Such reasons include, but are not limited to, individual differences among schools in the quality of organizational resources used to help clients, individual differences in caregiver abilities and skills, or unanticipated random events that are outside the control of either caregiver or client (see also Individual Differences chapter of this text).

Conceptual Confusion in Distinguishing Between and Among Subgroups Tremendous subgroup diversity exists within the broad groups of European, Black, Hispanic, Asian, and Native Americans (LoConto & Francis, 2005; Lopez, Lopez, Suarez-Morales, & Castro, 2005; Michaelis, 1997; Thao, 2005; Wood, 2003; Worrell, 2005; Yoon & Cheng, 2005). Some critics argue that the practice of assigning individuals to mutually exclusive categories based on race or ethnicity (for the purpose of determining appropriate counseling methods) is problematic because cultural, language, and behavioral traits overlap in various degrees across groups as a function of "normal" individual differences within groups and acculturation processes between groups (Patterson, 2004). Thus, group boundaries are not rigid but are fluid and permeable – as numerous "cultures" exist within any one racial group and numerous races exist within any one cultural group.

According to Kirmayer (2012), a complicating issue involves the difficulty in translating the meaning of cultural differences smoothly from one country to another. He argues that efforts to understand general cultural competence principles are made more difficult due to the fact that "definitions of culture at play in the US reflect a particular history and politics of identity and therefore do not map neatly onto the distinctions among groups made in other countries" (p. 150).

Conceptual Confusion in Distinguishing CC from Other Forms of Competence In establishing the construct validity of new construct, advocates and researchers must show how the new construct differs both conceptually and empirically from similar constructs (Mackenzie, 2003; Smith, 2005). Frisby (2009) argues that the CC movement has not sufficiently established conceptually whether or not the social competence construct (Schneider, Ackerman, & Kanfer, 1996) (1) subsumes cultural competence and (2) is a necessary but not sufficient condition for cultural competence or (3) whether social competence and cultural competence are independent constructs.

Coleman (1998) designed a study to test the hypothesis that general and more specific multicultural counseling competence could be perceived as distinct constructs. Coleman had graduate students and ethnic minority social psychology undergraduates watch two videotapes depicting the same white counselor counseling an ethnic minority client. The first tape depicted the counselor displaying both general counseling competence and culturally sensitive counseling skills, and the counselor in the second tape displayed general counseling competence and culturally "neutral" cultural sensitivity. Participants rated the counselors in the two tapes on a general counseling competency scale and a multicultural competency scale. Coleman found that both groups of participants perceived the counselor in the "culture neutral" vignette to have less multi-

cultural and general counseling competence – which "raises the question of whether these are distinct constructs" (p. 153).

Pope-Davis, Liu, Toporek, and Brittan-Powell (2001) acknowledge that serious research which attempts to answer this question (i.e., whether or not multicultural and general counseling competencies are distinct constructs) poses a threat to the fundamental political goal of multiculturalism – "which is to transform traditional psychology to make it more relevant for diverse populations" (p. 130). They write:

> [Multicultural] research seems to be at risk if results do not support any significant differences between a multiculturally competent counselor and one who is generally a competent (i.e., not multiculturally competent) counselor. (p. 130)

Empirical Critiques

The term "empirical" is defined broadly to mean any investigation that collects data and analyzes data in order to gather information, support or refute an argument, or test a hypothesis. Obviously, to review all such activities connected to the cultural competence movement is well beyond the scope of this chapter. This section more narrowly focuses on results from empirical studies that call into question one or more of the core components of cultural competence theory and advocacy.

General Shortcomings in CC Research A common theme voiced by CC advocates is the lack of empirical research to effectively support many claims in the CC movement. As an example, Sue et al. (2009) opine that cultural competence definitions pose problems in terms of empirical testing, as characteristics of culturally competent therapists or human interaction processes are difficult to specify and operationalize for research (Sue et al., 2009, pp. 529–530). According to Sue et al. (2009), 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 (p. 527). Weinrach and Thomas (2004) echo this observation and object to CC advocacy on the grounds that the relationship between race/ethnicity and mental health functioning is poorly understood, which precludes making clear predictions of cultural influences on mental health (Weinrach & Thomas, 2004). Pope-Davis, Liu, Toporek, and Brittan-Powell acknowledge that little research supports the assumption that racially/ethnically diverse clients seek out culturally competent counselors for treatment (p. 125). Sue et al. (2009) opine that it has been difficult to develop research strategies, isolate components, devise theories of cultural competency, and implement training strategies. They summarize the limitations in cultural sensitivity or competency research as being a function of the fact that these constructs (*a*) have various meanings, (*b*) include inadequate descriptors, (*c*) are not theoretically grounded, and (*d*) are restricted by a lack of measurements and research designs for evaluating their impact in treatment (Sue, Zane, Hall, & Berger, 2009, p. 530).

Even those who support cultural competency advocacy admit that the effectiveness of multicultural training has not been empirically determined conclusively and that no evidence exists showing that practitioners who adopt multicultural counseling competencies will be better counselors compared to those who do not (Braden & Shah, 2005; Neville et al., 1996; Sue, 1998; Weinrach & Thomas, 2002, 2004; for a dissenting view, see Worthington, Soth-McNett, & Moreno, 2007). The empirical and associated pedagogical problems with multicultural competencies, as applied to the mental health counseling profession, are succinctly summarized as follows from Weinrach and Thomas (2004):

> There is insufficient evidence that cultural differences account for sufficient variance in the mental health of clients from different groups to justify unique treatment protocols. And even if there were sufficient evidence, the myriad of permutations of protocols would be impossible to achieve. (p. 82)

Weinrach and Thomas (2002) articulate four specific shortcomings of empirical research that undermine the construct validity of cultural

competence: (1) lack of consistency among multiple raters as to mastery of cultural competence, (2) lack of stability in demonstrating cultural competence from one setting/situation to another, (3) lack of generalization of cultural competencies from simulated to "real-life" situations, and (4) lack of construct validity of professional organization's cultural competency documents with what counselors actually do in multicultural counseling settings.

At the conclusion of a 20 year literature review of multicultural counseling competencies research, Worthington et al. (2007) opined that multicultural competencies appear "to be more thoroughly *discussed* than they are actually *investigated* in the literature" (p. 357; see also Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005), although they expressed optimism that this trend seems to be reversing at the time of their writing.

Disparity Interpretation Errors As discussed in the chapter on the History and Development of Cultural Competence Advocacy, racial/ethnic statistical disparities in the quality of mental and physical healthcare are one among many justifications of the need for cultural competency training. In the context of analyzing health disparities in the quality of treatment received within the healthcare system, however, Klick and Satel (2006) argue that researchers can arrive at incorrect conclusions when they fail to statistically control or account for "third factors" that are correlated with race, which in turn can influence the quality of care received in the healthcare system. As examples of third factors, racial/ethnic disparities already exist in the type of insurance coverage patients hold (e.g., insured, uninsured, or underinsured; public versus private health plans; profit versus not-for-profit health plans), quality of physicians with whom patients interact (as racial groups do not visit the same population of physicians), regional variations in medical practices (as healthcare quality varies as a function of where people live – and different racial groups tend to live in different geographical areas), and individual differences in patient characteristics such as health literacy or the clinical features of the medical problems for which they are seeking treatment.

They argue that when more careful researchers control for such factors, "the magnitude of the race effect shrinks considerably, if it does not disappear altogether" (p. 4).

Results from Clinician Surveys As shown in previous chapters, cultural competence is portrayed as an urgent need for pre- and in-service clinicians who presumably lack such skills. Huey, Tilley, Jones, and Smith (2014) reviewed survey studies showing results that challenge the assumption that clinicians poorly attend to cultural issues when treating ethnic minority clients (e.g., see Allison, Crawford, Echemendia, Robinson, & Knepp, 1994; Hansen et al., 2006; Holcomb-McCoy & Myers, 1999; Lopez & Hernandez, 1986; Maxie et al., 2006). According to Huey et al. (2014), survey data collected since the middle 1980s report that the majority of therapists (who are predominantly white) "feel competent to work with ethnic minorities, discuss race/ethnicity issues when relevant to the presenting problem, feel reasonably comfortable discussing issues of ethnic difference with clients, consider race/ethnicity when constructing case formulations, and pursue additional resources when they are unfamiliar with the clients' culture" (p. 324).

CC Measurement Criticisms Measures designed to assess cultural competence have been criticized as putting too much emphasis on self-report methodology (Weinrach & Thomas, 2002). Self-report scales have been criticized for their failure to address social desirability effects (Constantine & Ladany, 2000), which can be defined as the tendency of respondents to answer questions (particular on sensitive topics) in a manner that would be viewed favorably by themselves or others. Social desirability influences respondents to over-report good attitudes/behaviors while under-reporting bad attitudes/behaviors (Fisher, 1993). As a result of these problems, later cultural competence scales (across a variety of disciplines) have incorporated items designed to measure social desirability (e.g., see Bernhard et al., 2015).

Cultural competency scale development in applied counseling has exposed a number of weaknesses cited by scholars, which include the lack of significant conceptual and/or empirical relationships among scales purporting to measure the same construct (see review in Worthington et al., 2007). Studies of the validity of self-report measures of multicultural counseling competencies have shown little correspondence among the subscales of the most frequently used measures, as well as a lack of correspondence between cultural competency self-reports and observer ratings (Constantine, 2001; Ponterotto, Fuertes, & Chen, 2000; Worthington, Mobley, Franks, & Tan, 2000).

Atkinson and Israel (2003) expressed serious reservations about the hasty acceptance of four cultural competency assessment instruments developed during the early 1990s (D'Andrea, Daniels, & Heck, 1990; LaFromboise, Coleman, & Hernandez, 1991; Ponterotto, Sanchez, & Magrids, 1991; Sodowsky, Taffe, Gutkin, & Wise, 1994) that were adopted by the counseling psychology profession but turned out to measure nothing more than "self – efficacy for [multicultural counseling competencies], not [multicultural counseling competency] itself" (p. 595). When Constantine and Ladany (2000) controlled for social desirability effects before correlating several cultural competence self-report measures and a behavioral measure of multicultural case conceptualization ability, they found no significant correlation.

Larson and Bradshaw (2017) identified 15 studies that address issues related to cultural competence scales and social desirability bias. Collectively, the studies used ten cultural competence scales taken by respondents from the disciplines of counseling, marriage/family therapy, teaching, collegiate student affairs, and nursing. Their review concluded that measured cultural competence is positively correlated with social desirability bias (as measured by a separate social desirability scale); however, the strength of this association varied as a function of the particular cultural competence scale used (for a research study that found no correlation between measured cultural competence and social desirability, see Reyna, 2014).

Methodological Rigor of CC Training Evaluation Price et al. (2005) evaluated 64 articles published between 1990 and 2003 that used cultural competence training for healthcare providers as a strategy to improve the healthcare of minorities. They concluded that the quality of evidence for the improvement of health professionals' cultural competence was poor. Specifically, less than a third of the reviewed studies provided quality criteria for describing the targeted health service providers or described CC interventions taught to healthcare providers. Few of the studies reviewed included adequate control groups necessary for accurately detecting and interpreting the effects of training. Many of the studies did not use objective evaluation procedures, which undermined study validity. Most studies reviewed measured changes in health providers' attitudes and knowledge as opposed to changes in their behaviors or patient outcomes, which the authors interpreted as being a function of studying students rather than actual practitioners. Few studies reported quantitative data that would indicate the strength of the pre- and post-test differences between groups of variability in outcomes (e.g., confidence intervals).

Bhui, Warfa, Edonya, Mckenzie, and Bhugra (2007) evaluated 109 scholarly papers published since 1985 that described and/or evaluated models of cultural competence in mental health settings in North America. Only 9 out of the 109 papers actually described implementation of a cultural competence model of mental healthcare (by psychiatrists, nurses, medical students, and multidisciplinary teams) as well as provided evaluation data for service provision or training. Of these nine studies, only three provided quantitative outcomes, published their teaching and learning methods, or actually followed up subjects to assess changes in behavior or adherence to the cultural competency model following the intervention. Huey et al. (2014) reviewed these and other studies before concluding:

> Literature reviews mostly agree that there is little in terms of rigorous evaluation to guide policy decisions about the utility of training clinicians in cultural competence …. The use of appropriate control groups is rare, client samples are analogue rather than clinical, cultural competence evaluations are based almost exclusively on therapist self-report, and evidence linking therapist cultural competencies to client outcomes is sparse. Despite several decades of research, we know very little about (a) the threshold for adequate cultural competence among clinicians, (b) which training approaches increase cultural competence in clinicians, and (c) whether cultural competence can be reliably differentiated from generic clinical competence (p. 322)

Horvat, Horey, Romios, and Kis-Rigo (2014) assessed the effects of cultural competence education for healthcare professionals on patient-related outcomes, health professional outcomes, and healthcare organization outcomes by conducting an exhaustive literature review of randomized controlled trial (RCT) up until the middle of 2014. The studies reviewed involved approximately 8400 patients, 41% of whom were from culturally and linguistically diverse backgrounds in the United States, Canada, and the Netherlands. The authors found that their review either showed support for the cultural competence education or no evidence of an effect. They concluded that the quality of evidence was insufficient to draw generalizable conclusions, largely due to heterogeneity of the interventions in content, scope, design, duration, implementation, and outcomes selected.

Benuto, Casas, and O'Donohue (2018) reviewed 17 training studies (spanning a 30 year period) that evaluated the outcomes for psychologists trained for multicultural competency. They note that 9 of the 17 studies were published prior to the publication of the APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists in 2002 (American Psychological Association, 2003). Training mechanisms included lectures, discussions, utilization of case scenarios, cultural immersion activities, role-playing exercises, contacts with diverse individuals, self-reflections of interactions with clients, journaling activities, and service learning experiences. Across the studies reviewed, topics covered in the curricula included racism/discrimination, worldviews, cultural identity, general concepts about culture, and the nature of biases. The authors found that the majority of studies indicated positive changes with regard to knowledge. However, outcomes with regard to attitudes, awareness, and self-reported and objective skills were mixed, with some studies identifying positive changes after training and other studies not identifying significant changes. The authors opined that synthesizing the outcomes of cultural competency training research was a challenging task – given the limited amount of information included in the published literature about the studies themselves, the varying outcome variables assessed across studies, and the varying methodologies used across studies.

Racial/Ethnic Matching of Helpers/Clients The entire justification for cultural competence training rests on the assumption that racial/ethnic differences between helpers and clients necessitate specialized cultural competency training for helpers. The unspoken implication is that helpers and clients who come from the same racial/ethnic group enable the helper to be more effective to some unspecified degree. This enables researchers to test the hypothesis that racial/ethnic matching of helpers and clients leads to demonstrably greater effects compared to helpers and clients that are not racially/ethnically matched.

Marimba and Hall ((2002) identified and examined seven ethnic matching psychotherapy studies published between 1977 and 1999, all of which involved three dependent variables: (1) dropping out, defined as the failure of the client to return for a second session after the initial session; (2) utilization, defined as the number of sessions attended; and (3) global assessment score, which measures the degree of overall functioning on a continuum from psychiatric disturbance to psychiatric health. The authors found very small effect sizes in favor of ethnic matching

(ES = 0.01–0.04) but concluded that these effect sizes were too small to provide support for ethnic matching as a promising variable for improving client outcomes.

Cabral and Smith (2011) conducted a meta-analysis of three variables frequently used in research on racial/ethnic matching: (1) clients' preferences for a therapist of their own race/ethnicity, (2) clients' perceptions of therapists, and (3) therapeutic outcomes. Although the average effect size from analyses of the first two questions (involving 52 and 81 studies, respectively) was $d = 0.63$ (client preferences) and $d = 0.32$ (client perceptions), the effect size for therapeutic outcomes (involving 53 studies) was d = 0.09, "indicating almost no benefit to treatment outcomes from racial/ethnic matching of clients with therapists" (p. 537).

Treatment Effect Research Lau, Chang, Okazaki, and Bernal (2016) organized a review of the literature on psychological/mental health treatment outcomes for ethnic minorities around three paradigms in treatment outcome research: (1) the generalizability of treatment effects (evidence-based treatment efficacy and effectiveness), (2) the adaptation of treatment (cultural adaptations to evidence-based treatment efficacy and effectiveness), and (3) innovations in treatment development (culturally sensitive treatment efficacy and effectiveness).

Generalizability of Evidence-Based Treatment (EBT) Effects for Racial/Ethnic Minorities Evidence within this category generally refers to treatments that have been validated on samples that are not racial/ethnic minorities but can be evaluated for their effectiveness when applied to racial/ethnic minorities.

As discussed in the History and Development of Cultural Comptence chapter, aggressive cultural competence training advocacy is often justified from the suspicion that racial/ethnic disparities in mental health indicators may be due, in full or in part, by the lack of cultural competence in clinicians. From this reasoning, it should follow that "traditional" treatments (that include no specific adaptations for the race/ethnicity of clients) should be largely ineffective or harmful when applied to nonwhite clients.

Huey et al. (2014) reviewed the literature on psychotherapy outcomes for culturally diverse youth and families, as well as summarized evidence from more than 300 randomized trials of mental health treatments that (a) included predominantly ethnic minority participants, (b) assessed how client ethnicity affects treatment outcomes, or (c) evaluated separate treatment effects for ethnic minority participants (p. 311). The majority of the literature they reviewed focused primarily on African-Americans and Latinos living in the United States, with a smaller number of trials targeting Asian-Americans, Native Hawaiians, Native Americans, and ethnic minorities living in Australia, New Zealand, and a number of other European countries. They found that the number of minority-focused randomized trails increased steadily over the 40 years prior to publication of their review (beginning in the 1970s). In particular, since the establishment of the National Institute of Mental Health (NIMH) policy requiring clinical research grantees to include women and minorities in 2001, this number increased dramatically.

Huey et al. (2014) also found that therapies which served minorities appeared to be effective across a broad range of mental health problems (including anxiety, depression, externalizing problems, schizophrenia, substance abuse, smoking, and trauma). In addition, evidence from a subset of studies showed promise in "attracting minorities into treatment, keeping them involved in therapeutic activities, improving the client-therapist relationship, and preventing minorities from terminating treatment prematurely" (p. 312).

Huey et al. (2014) investigated the extent to which treatment outcomes are similar for whites and racial/ethnic minorities or whether treatment outcomes for whites are superior to those for racial/ethnic minorities (i.e., race/ethnicity as a moderator effect). Their review of 29 meta-analyses showed 62% reporting no significant ethnicity

effects, 14% reporting outcomes favoring whites, 17% showing superior outcomes for racial/ethnic minorities, and 7% showing mixed or indeterminate outcomes (p. 314). When substance use meta-analytic studies were examined separately (N = 12), 33% showed no race/ethnicity effects, 25% showed superior outcomes for whites, and 42% reported better outcomes for ethnic minorities. When Huey et al. (2014) reviewed four meta-analyses for investigating whether some racial/ethnic groups benefit more from psychotherapy compared to others, no racial/ethnic differences in treatment outcomes were found – except for one meta-analysis (Smith, Rodríguez, & Bernal, 2011), which showed that Asian-Americans benefited more from psychotherapy than did African-Americans, Latinos, and Native Americans. From these reviews, Huey et al. (2014) conclude:

> Thus, on average, psychotherapies appear to work equally well for whites and ethnic minorities …. Overall, these results appear to support an "ethnic invariance" perspective, with the caveat that certain treatments may favor white participants under some circumstances but ethnic minorities under others. In addition, treatment outcomes across ethnic minority groups were quite similar, with one notable exception. One important limitation of these "ethnicity-as-moderator" studies is that the role of cultural competence is mostly obscured. (p. 315)

According to Lau et al. (2016), large literature reviews support the generalizability of evidence-based treatments for racial/ethnic minorities (Huey & Polo, 2008; Miranda et al., 2005). However, EBT outcomes show more mixed results as a function of the statistical design used, the clinical problem that was the focus of treatment, and the acculturation levels of clients (for details, see Lau et al., 2016).

Efficacy and Effectiveness of Cultural Adaptations to Treatment for Racial/Ethnic Minorities

Evidence within this category generally refers to treatments that have been validated on samples that are not racial/ethnic minorities but have been adapted to some degree in order to provide a better fit for the cultural characteristics of racial/ethnic minority clients, and "there is a plausible threat of EBT generalization failure" (Lau et al., 2016, p. 37). Adaptations generally are made in order to accomplish one or more of two broad goals: to enhance the engagement of minority groups in the treatment and/or to contextualize the content of the treatment to better fit the needs of the target group.

Examples of cultural adaptations include the provision of treatment in the preferred language of the clients, directly addressing cultural myths about the clinical problem and/or treatment, changing the name of treatment where appropriate in order to avoid stigma, the provision of child care or transportation to ensure and permit attendance for treatment, ensuring that treatment is accessible within community sites in which clients reside, the depiction of ethnic minorities in graphic materials, or altering depictions of activities that are more culturally familiar to clients (e.g., see Graves et al., 2016).

From their review of five large meta-analyses of culturally adapted treatments (e.g., Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Huey & Polo, 2008; Smith et al., 2011; van Loon, van Schaik, Dekker, & Beekman, 2013), Lau et al. (2016) report finding significant effects for cultural adaptation in four meta-analyses but nonsignificant effects for one. Lau et al. (2016) interpret this disappointing finding as due to the poorly specified or superficial nature of the adapted treatments, leading to a failure to effectively distinguish among treatments on the basis of the quality or content of the cultural adaptations (p. 42).

Huey et al. (2014) employed the overarching term "cultural tailoring" to describe aspects of studies which use the terms "culturally adapted" and "culturally sensitive" to depict treatment modifications (in addition to using the term "cultural tailoring"). These researchers summarized results from ten meta-analyses that evaluated culturally tailored interventions for ethnic minority youths and adults. They concluded that all ten meta-analyses showed culturally tailored interventions to be efficacious for racial/ethnic minorities; however, authors of the studies they reviewed differed in their conclusions regarding the specific benefits of cultural tailoring. They write:

> Overall, these findings present a mixed picture of the benefits of cultural tailoring. Although culturally adapted treatments are clearly efficacious with ethnic minorities when compared to conventional control groups, it is less evident whether culturally adapted interventions are more efficacious than un-adapted interventions. Some meta-analyses suggest that cultural tailoring may be a powerful tool for enhancing treatment effectiveness for ethnically diverse groups …. However, other meta-analytic evidence suggests that some forms of cultural tailoring may provide little added benefit to ethnic minorities compared to standard treatments and, in some cases, may even reduce treatment effectiveness …. Further research is needed to understand the effects of cultural tailoring and determine what forms are effective and for whom. (p. 320)

Huey et al. (2014) evaluate these findings as somewhat ambiguous, since the randomized controlled trials typically involve comparing a culturally tailored treatment to no treatment, a placebo, or treatment-as-usual controls. This type of design evaluates the efficacy of an overall intervention rather than the specific effects of cultural tailoring (p. 321). They nevertheless view results from studies that use moderator analyses as helpful for providing at least preliminary clues as to which types of cultural tailoring might be most efficacious. They mention six conclusions that show some helpful evidence:

1. Cultural tailoring aimed at a specific ethnocultural group is more effective than tailoring targeting a mixed group.
2. Matching clients with therapists who speak their preferred (non-English) language may improve treatment outcomes.
3. Cultural tailoring may be most effective for older, less acculturated clients.
4. Therapist/client congruence on therapeutic goals and using metaphors/symbols that match the clients' cultural worldview may strengthen treatment efficacy.
5. Myth adaptation that incorporates the clients' beliefs about symptoms, etiology, course, consequences, and appropriate treatment may improve treatment outcomes.
6. Addressing cultural factors implicitly rather than explicitly may be one promising way to capture the benefits of cultural tailoring without the risk of iatrogenic effects (i.e., illnesses caused by a medical treatment or diagnostic procedure) (pp. 320–321).

Efficacy and Effectiveness of Innovative Culturally Sensitive Treatments (CSTs) for Racial/Ethnic Minorities Evidence within this category generally refers to the efficacy of novel interventions that originate out of the cultural milieu of specific racial/ethnic minority communities. According to Lau et al. (2016), CSTs can be distinguished from culturally adapted EBTs (see previous section) in that CSTs are healing traditions, cultural practices, alternative cultural healing philosophies, or heritage folk practices that are not typically represented in the "mainstream" literature of EBTs.

In their review of a small sample of studies, Lau et al. (2016) found encouraging results for the efficacy of CSTs (e.g., Brody, Murry, Kim, & Brown, 2002; Costantino, Malgady, & Rogler, 1986; Gonzales et al., 2012; Kogan et al., 2012). However, there were not enough studies conducted in their review to definitively address whether CSTs work as well as EBTs or to clearly explicate the specific mechanisms that would explain why CSTs were effective.

Client Outcome Research Although some client outcome research (on the effects of counselor multicultural competencies) has investigated client perceptions of counselor characteristics, client attrition, and client satisfaction with counseling, no client outcome studies have investigated actual client *behavioral change* as a result of counselors' cultural competencies (Worthington et al., 2007, p. 358). In addition, those studies that demonstrated positive effects were limited by the almost exclusive use of analogue designs (i.e., using artificial conditions, settings, or subjects that simulate real-life condi-

tions, settings, or subjects; Worthington et al., 2007).

Zane, Bernal, and Leong (2016) coined the term "criterion problem" in describing "the lack of research evidence that a culturally competent therapist produces better client outcomes than a therapist who is not deemed culturally competent" (p. xiii). They explain this condition as being attributed to the CC movement focusing overwhelmingly on caregiver training rather than on actual therapeutic outcomes.

Philosophical Critiques

Objective empiricism is rooted in the time-honored axiom of "follow the data wherever it leads" – which also involves having the courage to "discard contemptuously whatever may be found [to be] untrue" (Sir Francis Galton, quoted from Pearson, 1914, p. 297). The hallmark of objective empiricism is the dogged pursuit of truth, primarily, and then finding the best evidence-based solutions for solving practical problems, secondarily (Frisby, 2013, p. 519). Ideally, there are no "sacred cows" in science, as all knowledge claims are open to evaluation, scrutiny, and debate – in the hope that more accurate knowledge will be discovered (Frisby, 2013, p. 519).

Unfortunately, as the material in the previous section has shown, the empirical evaluation of cultural competence theory and practice is extremely challenging and complex. Here, empirical findings from large literature reviews and rigorous meta-analyses include many caveats and nuances – which invite extreme caution with respect to how to interpret the implications of this literature. At the very least, the fruits of the hard work that scholars have devoted to the empirical evaluation of this literature should encourage reasonable observers to appreciate the fact that *the construct validity of cultural competence is far from settled*. Nevertheless, the existence of, and need for, cultural competence is depicted as "settled law" for many observers. Long before any of the research described in the previous section was undertaken, Ridley, Mendoza, and Kanitz (1994) asserted:

> Consequently, the issue of whether or not to include some form of [multicultural training] in graduate training is no longer open for debate. (p. 227)

This causes many critics to argue that the cultural competence movement – either in its foundational assumptions, content, research agendas, or practical/professional applications – is fueled by an aggressive *sociopolitical ideology* rather than by dispassionate science (see O'Donohue & Benuto, 2010; Paasche-Orlow, 2004; Vontress & Jackson, 2004). When this happens, critics argue that both psychological science and applied practice are subsequently corrupted to varying degrees (Frisby, 2013; Lilienfeld, 2017; Lilienfeld, Lynn, Ruscio, & Beyerstein, 2010; Wright & Cummings, 2005).

Sociopolitical ideologies begin with a constellation of popular and persuasive *narratives*, which are easily identified by four predictable characteristics (Frisby, 2013). First, sociopolitical ideologies are framed as urgently necessary in order to fight an injustice in society. As seen in the History and Development of Cultural Competence chapter, for example, cultural competence advocacy is often justified on the basis of its perceived value in correcting "unjust" statistical disparities in psychological/health services (e.g., see Minnesota Evidence-Based Practice Center, 2016). Second, sociopolitical ideologies must oversimplify life's complexities so that moral/philosophical battle lines can be crystallized more clearly in the minds and hearts of followers. As one example, the cultural competency movement has been criticized as oversimplifying race/ethnicity as the "primordial" factor that determines the quality of psychological services (see criticisms by Satel & Forster, 1999; Weinrach & Thomas, 2002). Third, sociopolitical ideologies have their own specialized lexicon in order to communicate its ideas more parsimoniously among advocates. As examples, recipients of cultural competency training in applied psychology must be familiar with various specialized terms such as "social justice," "privilege," "oppression," "microaggressions," "othering," "marginalization," and "intersectionality" – to name a few. Fourth, sociopolitical ideologies must

enforce conformity by rewarding followers and punishing dissenters (for examples within the cultural competency movement, see Jacoby, 2017; Levitt, 2005; Rogers, 2006; Rudow, 2013; Satel & Forster, 1999; Starnes, 2016). Levitt (2005) writes:

> "Cultural competence" is, in essence, a bureaucratic weapon. "Cultural competence," or rather, your presumed lack thereof, is what you will be clobbered with if you are imprudent enough to challenge or merely to have qualms about "affirmative action," "diversity" and "multiculturalism," as those principles are now espoused by their most fervent academic advocates. Cultural competence … is something a professor is supposed to keep handy at all times … in order to dispel any suspicion of racism, sexism or Eurocentrism that might arise in the minds of the professionally suspicious

Although cultural competence advocacy is decorated by the trappings of science (i.e., data-based studies, journal publications, scale development, "best practices" documents by professional guilds, conference presentations, etc.) – critics argue that the fundamental agenda of such narratives is not the disinterested search for truth. Levitt (2005) acknowledges that the original meaning and application of the term "cultural competence" was designed to assist healthcare professionals to function effectively with persons from ethnic minority and immigrant groups. Over time, however:

> [C]ast loose from its original moorings, the phrase [cultural competence] has become emphatically political …. In the context of higher education, cultural competence necessitates abject refusal to articulate or defend ideas that might make certain protected groups uncomfortable

O'Donohue and Benuto (2010) argue that "cultural sensitivity" (one of the many synonyms for "cultural competence" - see History and Development of Cultural Competence chapter, this text) in applied psychology is little more than a means by which whites can assuage their "white guilt" (Steele, 2006) – as opposed to doing anything concrete that actually helps disadvantaged minorities. In this process, the constant emphasis on the infusion of cultural competence (i.e., "sensitivity") requirements, guidelines, directives, and policies by professional organizations and institutions is an effective way for demonstrating to themselves and others that they are not racists (Steele, 2006).

According to some critics, the driving goal of sociopolitical ideologies is to *promote*, *protect*, *and sustain the ideology at all costs* – regardless of what data reveals (or does not reveal). To do this, large bodies of relevant research that are damaging to the ideology must be ignored, kept offstage, vigorously attacked, or spun in ways that ultimately reinforce the ideology (Frisby, 2013; Gottfredson, 1994; Phelps, 2009; Wright & Cummings, 2005). Although consensus exists among critics as to the palpable influence of sociopolitical ideologies in guiding the cultural competence movement, critics differ as to the names given to these ideological influences.

Redding (2001) argues that American psychology in general lacks sociopolitical diversity, which results in an overwhelming identification by both practicing and research psychologists with *political liberalism*, which is also the perspective that dominates higher education (Gross, 2013; Langbert, Quain, & Klein, 2016; Maranto, Redding, & Hess, 2009; Pew Research Center, 2016; Yancey, 2017). According to Redding, not only are politically conservative psychologists underrepresented in American psychology, but research, advocacy, and professional practice/policy positions advocated by psychology guilds are more often than not politically liberal as well. In his view, this viewpoint imbalance is what corrupts research, clinical practice, and the education of psychologists (for a more elaborated discussion, see chapter on Viewpoint Bias, this text).

Writing from the perspective of school psychology, Frisby (2013) uses the term *Quack Multiculturalism* to describe the sociopolitical ideology that misleads audiences as to what actually facilitates positive psychoeducational outcomes for racially/ethnically diverse school children. Frisby defines Quack Multiculturalism as "that subset of ideas – promoted under the banner of multiculturalism – that is aggressively sold to audiences despite having no serious research support, or in some cases is blatantly contradicted by quality research" (p. 57). Frisby

(2013) argues that Quack Multiculturalism is pervasive in writing on diversity issues within school psychology because it satisfies emotional needs in audiences for "quick fixes" in solving complex, difficult problems (p. 571).

Political correctness is a frequent term identified by critics that refers to the social pressure to self-censor or monitor one's language in favor of only "socially approved" language, the thinking of only "socially approved" thoughts, the public endorsement of certain "socially approved" viewpoints, or taking great pains not to acknowledge certain truths or observations that have the potential of giving offense to politically organized advocacy groups (based on gender, race, ethnicity, language, sexual orientation, disability, etc.) or their designated or self-appointed spokespersons (Frisby, 2013, p. 569).

According to Cummings and O'Donohue (2005), three major characteristics signal the presence of political correctness in American psychology. First, psychologists must be scared into changing their behavior by adopting a "the sky is falling" hysteria about an aggressively advertised "crisis." More often than not, the urgent "crisis" turns out to be a false narrative that eventually is revealed as baseless, only to be replaced by yet another "crisis" requiring immediate action. Second, politically correct thinking is noted by its easy acceptance of popular but incorrect ideas. When such ideas are challenged, however, there is no honest reexamination of the assumptions and/or evidence supporting the false idea. Third, political correctness is noted for its tendency to promote largely superficial actions that may indeed help persons to feel good about themselves, but without engaging in the difficult thinking and hard work needed to actually accomplish tangible results (Cummings & O'Donohue, 2005).

Restricted Sources of Variation in Human Behavior Some object to the cultural competency movement on the grounds that the movement encourages an overly restrictive view of the factors that influence human behavior. In the early 1950s, Kluckhohn and Murray (1953) established a robust principle for understanding similarities and differences among human beings. In their view, human similarities and differences are influenced by three sources: (1) characteristics and traits that persons share in common with all other human beings, (2) characteristics and traits that persons share in common only with smaller subgroups of which they are members (e.g., age, gender, racial, ethnic, language religious, socioeconomic, or geographic subgroups), and (3) traits that are unique to an individual that are not shared by any other person (Kluckhohn & Murray, 1953; Sue, 2001). Add to this the truism that individual and situational differences in behavior are influenced as well by the immediate context in which human beings operate (see Frisby, 2013, chapter 3).

These combined truths make the cultural competence movement vulnerable to criticisms that it exaggerates the role of racial/ethnic/language/cultural subgroup membership as the sole, the exclusive, or even the most important determinant of human psychological functioning and behavior (e.g., Frisby, 2005b; Satel & Forster, 1996; Weinrach & Thomas, 2004). Frisby (2005a, 2005b, 2013) calls this the *Difference Doctrine*, an influential assumption which holds that differences between racial, ethnic, language, and/or social class groups are so profound and mutually exclusive, that members within each group must necessarily require different assessment, counseling, and/or instructional techniques to adequately meet their psychological needs.

In short, this crit rceptions could be imagined or exaggerated (i.e., a true symptom of a psychological disorder).

Distortions of the Helper/Client Relationship Satel and Forster (1996) object to the CC movement's assumption that the doctor/patient relationship is fundamentally vulnerable to mistrust and communication simply because of racial/ethnic group differences. Others object to the presumption of racism on the part of helpers simply because they are white (Satel & Forster, 1996).

Promotion of Racism and/or Racialism Racism is a term that has been used, misused, and defined in a wide variety of ways (see chapter

on Race, Racial Differences, and Racism, this text). If racism is defined as the practice of stereotyping all members of a group based on the actions of a few, then some have suggested that cultural competency professional recommendations are consistent with a "racist" viewpoint (Weinrach & Thomas, 2002, p. 21).

Another pejorative term that is similar to racism, but describes a slightly different problem, is the term "racialism." *Racialism* is the belief that race and racial differences are fundamental to understanding differences in cognition, personality, and behavior. In racialist thinking, all members within racial subdivisions share certain heritable traits and characteristics that are presumed to be unique to that race and are not characteristic of members belonging to different races (see Frisby, 2013, p. 571). Some writers have argued that the fundamental principles that undergird the cultural competency movement are rooted in racialism. They argue that the constant emphasis on race is outmoded and incapable of providing an adequate explanation of the wide variety of circumstances and outcomes that are present in the human condition (Weinrach & Thomas, 2002). Others argue that racialist advocacy leads to the proliferation of and comfort with *liberal racism*, defined as "a condescending and patronizing set of assumptions about nonwhite minority groups which assumes that racial differences are so profound, and the social disadvantages and grievances associated with these differences to be so inevitable, that nonwhite groups cannot be expected to adhere to basic standards of morality and behavior assumed to be fundamental to a shared civic culture" (Frisby, 2013, p. 561; see also Sleeper, 1997).

Pedagogical Critiques

Critiques within this category object to the manner in which cultural competency is taught to pre- and in-service psychologists and counselors. A sampling of these critiques is discussed below:

Lack of Consensus on How to Train for Cultural Competence The lack of consensus as to how best to train for cultural competence appears to parallel the lack of consensus as to how it is defined. Bhui et al. (2007) write:

> There is considerable confusion about what constitutes cultural competence …. Despite a growing body of health and educational policies that prioritise cultural competency in health care provision, there is surprisingly little agreement on the meaning of cultural competence training or knowledge about its effectiveness. (p. 2)

Superficiality of Cultural Competence Training Some criticize cultural competence training as being somewhat superficial and cursory, which, in their view, potentially gives students a false sense of cross-cultural competency (Vontress & Jackson, 2004). Others have criticized training for cultural competence on the grounds that exercises designed to help students develop understanding, sensitivity, and/or empathy for groups different than themselves are "invasive," "synthetic," and "hollow" – as the "nuances of culture are too complex to absorb as a part-time observer" (Weinrach & Thomas, 2002, p. 30). Frisby (2013) has called the mindset that spawns such practices as "Light-and-Fluffy Multiculturalism" (see pp. 11–12).

O'Donohue and Benuto (2010) label this issue the "amateur anthropologist" problem (p. 35). They note that anthropologists spend years, decades, and even lifetimes studying specific cultural groups and even then express a degree of humility in acknowledging the limits of their understanding about such groups. Paradoxically, applied psychologists are presumed to possess "competence" about cultural groups from being exposed to brief units within what are often one-time courses.

Distorted Views of Clients Some object to cultural competence training on the grounds that it tends to perceive culturally diverse clients according to a "deficit model" (Weinrach & Thomas, 2004, p. 89). That is, clients from nonwhite, non-English-speaking groups are seen as automatic "victims" of society (in general) or of white psychological service providers (in particular) – solely on the basis of their group member-

ship (Ridley, 2005; Sue, 2010; Sue & Sue, 2016). These critics argue for a strengths-based model of mental health counseling that, in their view, is the only acceptable path for facilitating positive client growth (Weinrach & Thomas, 2004).

Content Imbalances Some object to cultural competence advocacy on the grounds that the cultural competency movement overemphasizes issues involving race yet overlooks and/or underemphasizes issues involving age, disability status, gender, and sexual orientation (Weinrach and Thomas, 2002). Even with this exclusively racial emphasis, multicultural competency standards have been criticized on the grounds that they overemphasize differences between groups to the near exclusion of similarities across groups or wide differences within groups (Frisby, 2013; Jackson, 1998; Weinrach & Thomas, 2002).

The Impossibility of Training for All Diversity Obviously, psychological/mental health treatments must be delivered to clients in a language that they can clearly understand. Other than this language matching issue, a fundamental justification for cultural competence training is the promise that students will learn specialized knowledge, awareness, and skills that will enable them to be uniquely effective with clients who are racially or ethnically different than themselves. Frisby (2013) coined the term *culture x treatment interaction* in referring to the idea that there exist unique treatments that are particularly effective for racial/ethnic minority clients but are not effective for nonminority clients (on the basis of some unspecified "cultural" modifications). This idea raises doubt among some critics, who argue that attempts to find methods that would be effective for every conceivable racial, ethnic, language, religious, socioeconomic, and cultural group (as well as accounting for seemingly endless permutations and combinations of these groups within individuals) constitutes a near-impossible task (Braden & Shah, 2005; O'Donohue & Benuto, 2010; Patterson, 2004). This is based on the argument that "everyone is a member of a class of one" (Patterson, 2004, p. 67) and that no mental health counselor can be prepared in preservice training to counsel every conceivable type of client.

Those who voice these criticisms argue for counseling methods based upon the common nature of all human beings (Patterson, 2004). As examples, some critics have argued that the quality of universal caregiver skills (e.g., rapport, warm, genuineness, good listening skills, empathy) is more beneficial than "culture-specific" caregiver skills or decontextualized information and knowledge (Fischer, Jerome, & Atkinson, 1998; Patterson, 2004; Pope-Davis et al., 2002).

Failure to Promote Critical Thinking Braden and Shah (2005) argue that "multicultural training is valid only if the assumptions underlying it are valid" (p. 1025). While critical thinking is obviously a fundamental requirement of case conceptualization training in applied psychology (John & Segal, 2015), some training programs make little to no sustained effort to help students develop thinking skills to critically evaluate the many implicit assumptions that underlie cultural competence advocacy (Frisby, 2013, 2015; see also Lilienfeld, Ammirati, & David, 2012). When this becomes habitual and long-standing, students and practitioners develop a general attitude of intellectual laziness toward multicultural issues (Frisby, 2013).

As examples, some critics object to cultural competence training on the grounds that the content of such training consists of vague platitudes and bromides that merely reflect common sense principles for understanding any client (Satel and Forster, 1996). A different criticism holds that race-/ethnicity-specific teaching curricula for developing cultural competence promote silly and/or lazy stereotypes – most of which are subjectively determined, not based on rigorous empirical evidence, and are descriptive of only small subsets of the groups for whom they broadly describe (Frisby, 2013; Satel & Forster, 1996, p. 14). To combat this problem, Frisby (2013, pp. 502–509) demonstrated how readers can apply simple critical thinking skills (e.g., defining terms, asking for evidence/data, examining hidden assumptions, identifying faulty reasoning) to textbook passages about

multicultural issues. O'Donohue and Benuto (2010) provide a series of critical questions that must be asked if clinicians are to critically sift through the numerous issues implicit in understanding what it means to be culturally sensitive to clients.

Promotion of Sociopolitical Advocacy Some critics object to the notion that training for proficiency in cultural competence requires sympathy (at the very least) or actual participation (at best) in activist sociopolitical causes (Satel & Forster, 1996; Weinrach & Thomas, 2004) – on the grounds that such activities have a dubious relationship to the *actual* job requirements of mental health services to individual clients.

Student Resistance to Perceived Indoctrination Criticisms within this category observe that the constant emphasis on race, racial identity, and morality plays involving narratives of "white wickedness/minority victimhood" alienates and upsets both white and nonwhite students, resulting in a variety of negative reactions and coping styles in cultural competency training (e.g., anger, silence, avoidance, and/or passivity; see Jackson, 1998; Reynolds, 2011; Sue & Sue, 2016; Sue et al., 2009). Such observations are not unique to cultural competency classes for psychologists and counselors, but have been reported to occur in higher education situations outside of these contexts (e.g., Flaherty, 2013; Smallwood, 2005).

Disconnect Between Suggested Practices and Real-World Realities When trainers attempt to give concrete examples of how to apply cultural competency principles, some have argued that the exemplars used violate empirical reality and/or a basic understanding of common sense (see discussion in Weinrach & Thomas, 2002, pp. 28–9). As an example, Jones (2013) discusses a task within cultural competence training that teaches students how to enact social advocacy in the workplace. The task involves assessing a school district's racial disproportionality rates (presumed to apply to special education enrollment), implementing a school-wide pre-referral intervention program (designed to reduce disproportionalities), and then assessing improved outcomes (i.e., defined as reductions in disproportionalities).

Such a task assumes that disproportionalities are reflective of defective pre-referral intervention practices, which constitute an "injustice needing correction." The reality, however, is that state racial/ethnic disproportionalities in special education enrollment have always been pervasive nationwide (e.g., Office of Special Education and Rehabilitative Services, 2016) – with federal policy, generally, and school psychology, specifically, having found no successful methods or programs that have eliminated them (Skiba, Albrecht & Losen, 2013).

Professional Best Practices Critiques

Observations within this category focus criticisms on mandates, position papers, and "best practices" guidelines issued by professional organizations for psychologists and counselors.

Advocacy Driven by a "Vocal Minority" Weinrach and Thomas (2002) cite one writer with many years of teaching experience in counseling who opines that multicultural competencies are based only on the views of a select group of highly vocal professionals – the intent of whom is to "impose a social activist political agenda" that "express[es] a specific point of view rooted in the racial hostilities of the 1960s" (pp. 24, 29). Satel and Forster (1996) opine that "radical multicultural therapy is not concerned with the integration of racial groups but with discrediting traditional therapy as an oppressive manifestation of a white-dominated culture" (p. 5).

Weinrach and Thomas (2002) have argued that the professional work group that developed multicultural standards for the counseling profession (at the time of their writing) did not use an established procedure such as the Delphi method (Garson, 2014) that could have been applied to the varied responses of a broad pool of academicians, practitioners, administrators, and clients (which could potentially have had a stronger impact on the counseling field). They

argue that this oversight has the potential to engender resistance from the field that can be easily avoided if more appropriate and democratic methods had been used. Support for using the Delphi technique has also been echoed at the conclusion of literature reviews on caregiver cultural competence in the healthcare professions (see Alizadeh & Chavan, 2016, p. e126).

Hasty Mandates Absent Consensus or Sufficient Research Some argue that a professional organization's acceptance and promotion of multicultural competencies (in guild best practices and ethics documents) are fundamentally inappropriate due to "a lack of consensus regarding their need, a paucity of research to support the efficacy of their use in improving the practice of [applied psychology], and a dearth of information about how to implement them, either in the classroom or in the field" (Weinrach & Thomas, 2002, p. 32). In addition, they argue (although speculatively) that malpractice claims against mental health professionals are likely to increase once clients are made acutely aware of the existence of cultural competence best practices/ethics documents within applied psychology.

Commenting on the multicultural counseling competencies identified by Sue et al. (1982), Sue, Arredondo, and McDavis (1992), Atkinson and Israel (2003) opined that the competencies are little more than aspirational statements that quickly and successfully captured the enthusiasm of the counseling psychology profession but nevertheless have not witnessed any serious efforts to empirically validate the competencies (for a rare exception, see Pope-Davis et al., 2002). They express serious reservations about the hasty acceptance of four cultural competency assessment instruments for counseling psychology developed during the early 1990s (D'Andrea et al., 1990; LaFromboise et al., 1991; Ponterotto et al., 1991; Sodowsky et al., 1994) that were adopted by the profession but turned out to measure nothing more than "self – efficacy for [multicultural counseling competencies], not [multicultural counseling competency] itself " (p. 595). Once social desirability is accounted for, no relationship was discovered between self-efficacy scores on these instruments and case multicultural case conceptualization ability (Constantine & Ladany, 2000; Ladany, Inman Constantine, & Hofheinz, 1997). Furthermore, they opined that policy initiatives on behalf of the CC movement have jumped far ahead of its research base, and "the reality is that very little research actually supports either the policy changes that have been implemented by the APA and other professional organizations of the MCC training models that have been an important feature of the movement" (pp. 593–594).

Critiques Related to Practice

Critiques within this category relate to perceived problems in the application of cultural competence to actual work with clients.

Questioning the Need for Multicultural Competencies Some scholars argue that the underlying conditions necessary to facilitate healing are universal regardless of whether or not the counseling involves multicultural issues (Fischer, Jerome, & Atkinson, 1998).

Qualitative research studies, in which participants give their unfiltered opinions within the context of individual or group interviews, provide actual data where practitioner views often *contradict* pronouncements from high-profile leaders in applied psychology professional guilds and organizations on the topic of cultural competency. As an example, Granello, Wheaton, and Miranda (1998) interviewed three focus groups consisting of African-American only, European American only, and a mixed-race group of state-agency rehabilitation counselors on the topic of multicultural competency skills, knowledge, and awareness. Among other findings, some interviewees rejected the practice of lumping all whites together into a homogeneous group that lacks ethnic diversity (when using skin color as the sole criterion for determining cultural identity). Particularly damaging for the

cultural competency movement were (1) their perception that good listening skills constituted the most important counseling competency for all cultural groups; (2) their skepticism about the usefulness of multicultural knowledge to counseling competency, particularly given its potential for stereotyping; and (3) their doubt about the existence of culturally specific skills and interventions that were uniquely effective for particular groups.

Potential for Ethical Violations Some have cautioned that it would be both ethnically and professionally unwise for practitioners to make clinical practice decisions on the basis of a perceived cultural competency mandate from one's professional organization – when that practice violates professional ethics or a given standard of personal morality (Paasche-Orlow, 2004; Weinrach & Thomas, 2004). These critics argue that the problems for which persons seek help may have nothing at all to do with a person's racial/ethnic/cultural group membership. Thus, for psychologists and counselors to automatically assume that they do (and to behave accordingly) would be to commit "a serious error in diagnosis and treatment" as well as behave in an "unprofessional" and "unethical" manner (Weinrach & Thomas, 2004, p. 83).

Sometimes critics will argue that ethics guidelines provide little to no insight for clinicians striving to be culturally competent in practice. O'Donohue and Engle (2013) cite a section of the American Psychological Association (APA) Ethics Code (American Psychological Association, 2010) which requires psychologists to obtain the training and expertise necessary to ensure "competence" of services that involve an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status. They argue that since no well-validated empirically supported treatments for specific cultural groups exist (at least at the time of their writing):

> [G]aining an appropriate level of competency as a prerequisite to working with certain groups, as required in the Ethics Code, is a complicated feat to accomplish and must depend on some other form of "professional knowledge." Given that there is no agreement in the field about what requisite knowledge entails, the field is left open to nearly any and every idea about how one might first identify a deficit of requisite knowledge, and then develop and maintain a level of competence sufficient to provide care …. This standard broadens the opportunity for psychologists who are attempting to be "culturally sensitive" to instead categorize and conceptualize a client from a perspective that could possibly cause harm. (p. 319)

To illustrate this problem, the authors give a hypothetical example of a Native American client from the Cherokee tribe, who suffers from a panic disorder. A "culturally sensitive" therapist, following the dictates for adhering to "culturally sensitive treatments" (see previous section on Empirical Critiques), may suggest that the client submit to a tribal healing ritual practiced for centuries. However, due to the dynamics inherent in the client's presenting problem, this treatment may do harm. In this hypothetical scenario, administering a treatment based on the client's cultural/ethnic affiliation would not be professionally "ethical" or even wise. In partial support for this possibility, Huey et al. (2014) report findings from an unpublished meta-analysis of culturally tailored versus generic treatments which concluded that tailoring effects resulted in negative effects nearly as often as they resulted in positive effects (Huey, 2013).

Living with Ambiguity Due to these inherent difficulties in applying cultural competence theory to practice, some have argued that applied psychologists must learn to live with a certain degree of "felt ambiguity" (p. 33) in their professional work, as mandating a uniform code of behavior based on cultural competency theory is little more than an exercise in futility (Weinrach & Thomas, 2002).

Critiques Offered as a Catalyst for Improving Cultural Competence Theory and Research

"Back to the Drawing Board"

Stuart opines that "[a]lthough it is easy to endorse the principle of culturally sensitive practice, it is often much harder to make it a reality" (p. 3). Even its most ardent supporters recognize that significant conceptual problems undermine cultural competence research. For example, Dr. Derald Wing Sue – who is generally credited with spearheading the aggressive introduction and subsequent development of cultural competency in American psychology – has remarked:

> 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 (Sue et al., 2009, p. 530)

Improving Theory Gallegos, Tindall, and Gallegos (2008) articulate a fundamental criticism of the cultural competence concept that raises serious doubts as to its legitimacy as a scientific construct. They argue:

> The concept of cultural competence has become ubiquitous in human services language and settings. Though the literature from various disciplines is replete with discussions on the topic, there still exists much disagreement regarding the definition of cultural competence as well as how to operationalize, test, and apply concepts related to cultural competence in social service settings. A related issue stems from debate regarding whether cultural competence is a theory, model, paradigm, framework, or perspective. Though cultural competence has been referred to as a theory by some scholars from different disciplines … there is still disagreement about whether the concepts related to cultural competence actually meet the criteria for a theory and, consequently, whether they can be used to generate hypotheses and allow for independent observations that can be used to continue building theory, conduct empirical research, and provide evidenced-based practice implications. (p. 51)

Material within the previous section has highlighted critics' contention that cultural competence advocacy is inextricably intertwined with sociopolitical ideology (Frisby, 2015; Levitt, 2005; Satel, 2000; Satel & Forster, 1999; Thomas & Wubbolding, 2009; Weinrach & Thomas, 1996, 2004). If cultural competence is to be viewed as a "legitimate" and nonpoliticized theoretical construct in science, then it must adhere to rules for what constitutes a "good theory." Theories are always subject to revision, testing, and refinement as scientific inquiry advances. Therefore, scientific theories are not portrayed as facts but are more accurately understood as statements of likelihood. The academic literature offers many definitions for what a theory is (see Gay & Weaver, 2011). Theories can be distinguished, in part, by adhering to the elements that distinguish good theories from merely "any theories" or at worse "bad theories." Wacker (2008) defines a "good theory" as "a fully explained set of conceptual relationships used for empirical testing" (p. 7). By pursuing criteria for good theories, researchers are better able to develop empirical studies that will have a lasting impact on their academic field (Wacker, 2008, p. 5). According to Wacker (2008), the following criteria (in part) characterize good theory in science:

Definitions Science can only advance as rapidly as the language that expresses its concepts (Wacker, 2008, p. 8). When researchers use ill-defined concepts, or assume that previously used concepts are adequate when in fact they are not, then researchers have little idea what they are measuring, testing, or discussing. Good theories adhere to the following criteria when using definitions for terms:

Conservation Property Good theories are careful to carefully distinguish terms from highly similar terms that may have been used in the past. This ensures that "new" words do not simply reflect the same concepts called by different names. As can be seen in the History and Development of Cultural Competence Advocacy chapter, words that comprise the term "cultural

competence" (CC) overlap considerably with at least a dozen similar terms found in a wide variety of disciplines both within and outside of the social sciences. A complicating matter is the fact that the cultural competence construct – as it has been used in applied psychology – has not been adequately differentiated from earlier concepts such as "social competence" (e.g., see Schneider et al., 1996). Specifically, researchers have not done the necessary empirical work to address questions of whether or not social competence subsumes cultural competence, if social competence is a necessary but not sufficient condition for cultural competence, or whether social competence and cultural competence are entirely independent constructs (see Frisby, 2009).

Uniqueness Property When terms used in one construct are similar to terms used in other constructs, then it increases the difficulty with which the uniqueness of the construct can be discerned. As shown in the History and Development of Cultural Competence chapter, terms such as "cross-cultural competence," "intercultural competence," "cultural sensitivity," and "cultural humility" are often used interchangeably, even by scholars within the same disciplines.

Parsimony Shorter, more concise definitions are preferred to longer definitions in order to reduce the risk of terms becoming too broad conceptually, which risks confusion with other terms. As shown in Table 2.1 from the History and Development of Cultural Competence chapter, definitions for cultural competence can be quite lengthy.

Theory Domain All other things being equal, better theories can be applied at more times and in more places than lesser theories. The wider the existing populations to which the theory can apply, the more generalizable the theory is. In addition, the degree to which a theory is independent of time and physical space requirements, the more abstract the theory is. Wacker (2008) calls the abstractness criterion "the ideal goal of theory [development]," because "the theory applies to all times and all places" (p. 10). Paradoxically, good theories must also "tell you what it cannot tell you." That is to say, a good theory outlines its own limitations as to what can or cannot be investigated, as some topics lie outside of the scope and parameters of the theory.

At the time of this writing, the scope and application of the cultural competence construct remain unclear. Frisby (2009) articulates this ambiguity as follows:

> Is [cultural competence] a nominal dichotomous variable, which clearly categorizes practitioners into those [who] are culturally competent versus those who are not? Or, are there degrees of cultural competence? If there are degrees of [cultural competence], how does the field characterize persons who have "more" [cultural competence] from those who have less? Is cultural competence a generalized continuous variable analogous to having a "cultural competence IQ"? Or, is cultural competence simply the accumulation of discrete uncorrelated skills? Can a person be culturally competent only in certain settings with certain groups, but also be culturally incompetent in other settings with different groups? (p. 869)

Explanation of Statistical Results When statistical analyses are applied to a research data, the manner in which statistical results are interpreted in support of a theory is another criterion that distinguishes among the quality of theories. The following key requirements are necessary for "good" theories (Wacker, 2008):

Fecundity In addition to explaining existing phenomena, good theories offer new areas for potential research. This quality causes good theories to be superior to existing theories that can only explain a limited pool of issues. By integrating more and more concepts into larger theories (that can explain more events), science is advanced.

Internal Consistency Good theories are logically consistent. As theories are composed of interrelated statements, all statements comprising the theory must be true at the same time in order for the theory to be internally consistent.

Parsimony The principle of Occam's razor holds that when deciding among competing hypotheses or theories for observations, the hypothesis or

theory with the fewest assumptions is preferred because it is the most testable (Sober, 2015). The tendency is for overly complex theories to incorporate ad hoc explanations for explaining inconvenient findings, whereas simpler and more parsimonious theories are better able to be falsified.

Predictability As stated earlier, good theories are able to be falsified (Popper, 2002). That is, good theories clearly state the conditions under which the theory can be refuted by independent researchers. Bad theories are theories that are designed in a manner that negates their ability to be disproved by independent researchers. Wacker (2008) argues that a bad theory can never be disproved because there are so many conceptual loopholes that would never allow the theory to be disproved (p. 7). If a bad theory is not disproved because of faulty construction, then this can lead to the equally faulty conclusion that the theory must be true. This then leads to the observation that, even if a theory promotes itself as "scientific," it is not scientific if it does not (or cannot) incorporate the potential for falsification.

In applying this principle, therefore, it is incumbent on cultural competence theorists to specify in sufficient detail the conditions that would falsify the validity of the cultural competence construct as a useful explanatory variable in applied psychological outcomes. For example, are there conditions for which a clinician possesses no skills that can be deemed "culturally competent," yet clients experience positive outcomes? Similarly, are there conditions for which a clinician possesses exemplary cultural competence, yet clients experience negative outcomes? As an example, how would cultural competence theory explain why clinicians and clients belonging to the same racial/ethnic group experience negative client outcomes?

Improving Measurement Depending on the field of study, the definition for a construct and the measurement of the construct are intimately intertwined. In the history of human intelligence research, rapid progress in the study of intelligence did not occur until the definition of intelligence was empirically operationalized as the *g* factor or the common factor responsible for positive nonzero correlations among all mental tests (Jensen, 1998). Before then, verbal definitions of intelligence given by experts did not yield anything coming close to a consensus. Jensen (1998) writes:

> No other term in psychology has proved harder to define than "intelligence." Not that psychologists haven't tried. Though they have been attempting to define "intelligence" for at least a century, even the experts in this field still cannot agree on a definition. In fact, there are nearly as many different definitions of "intelligence" as there are experts …. Therefore, the term "intelligence" should be discarded altogether in scientific psychology … [it] will continue, only because it can mean anything the user intends, and where a precise and operational definition is not important …. To put the study of mental ability on a firm scientific footing, we must begin by using theoretically neutral, objective, operational definitions. (pp. 46, 48, 49)

Objective observers can easily see the same conditions surrounding the term "cultural competence." Nevertheless, the cultural competence movement continues in its attempt to develop measurements of cultural competence despite having no commonly accepted consensus on its definition. As the content in Table 2.1 (see "*History and Development of Cultural Competence Advocacy*" Chap. 1, this book) indicates, definitions for cultural competence vary considerably. Here, the construct of cultural competence is not measured directly but instead consists of caregivers' subjective assessment of their own attitudes related to cultural competence or client ratings of the extent to which they feel that their counselor is culturally competent.

This leads to Wacker's (2008) second point, namely, that researchers cannot precisely measure what they cannot define precisely (p. 9). If terms used in a theory are vague, ambiguous, and ill-defined, then this leads to a plethora of measures that may yield contradictory results that are difficult to integrate into a clear conceptual whole. Furthermore, this disconnect between conceptual clarity and measurement leads to situ-

ations in which the use of measurements may lead to statistically significant results that are practically meaningless.

Worthington et al. (2007) opine:

> [I]t is impossible to measure actual multicultural counseling performance or skills via paper-and-pencil self-reports. Instead, measurement of skills should be based on observations of actual performance and should be highly contextualized – meaning that a counselor's score should be specific to each discrete performance, rather than based on global ratings assumed to generalize to future performances (p. 359)

Worthington et al. (2007) opine "we should be working toward the development of instruments that will assess knowledge, awareness, and skills that range from very broad and basic to very focused and complex" (i.e., that assess narrower segments of target populations, as in Latinos to Chicanos/Chicanas – see p. 360).

In a concise summary of a number of these criticisms, Gallegos et al. (2008) argue that "cultural competence" is not a scientifically useful theory because (1) what may be observed as culturally competent is given to value judgments, (2) cultural competence does not lend itself to prediction or measurement, (3) cultural competence lacks discernable or agreed-upon attributes, (4) cultural competence does not predict behavior, and (5) cultural competence lacks a dynamic relationship among (independent and dependent) variables (p. 56).

"Open Exploration into Previously Neglected Areas"

Some writers criticize cultural competence on the grounds that its current application is to some degree "too narrow," which in their view requires an expansion of advocacy efforts into new or under-researched areas.

Expand Pool of Groups for Study Many critics have argued that the cultural competency movement in mental health counseling, healthcare, and closely related fields has focused on only a few minority groups and in doing so has failed to be sufficiently inclusive in its attention to other minority groups. These critics mention women (Pieterse, Todd, Neville, & Carter, 2012; Priester et al., 2008; Weinrach & Thomas, 1996, 2002), the disabled (Eddey & Robey, 2005; Pieterse et al., 2012; Priester et al., 2008; Weinrach & Thomas, 1996, 2002), the elderly (Pieterse et al., 2012; Priester et al., 2008; Weinrach & Thomas, 1996, 2002), the overweight (Pieterse et al., 2012; Weinrach & Thomas, 1996), and the religious (Pieterse et al., 2012; Priester et al., 2008; Vieten et al., 2013) as groups deserving of increased attention.

Expand Areas of New Competencies Vieten et al. (2013) argue that, although religion and spirituality are important areas that define individual identity and living, religion/spirituality is not often discussed in psychotherapy, nor included in assessment or treatment planning, nor included in cultural competence training.

Expand Focus Outside of White Trainees Negy (1999) criticizes cultural competence training for its exclusive orientation to the training of white students, particularly as this relates to the assumption that racism and prejudice are unique to only whites (while failing to address bias of nonwhites against whites; Negy, 1999). In their comments on the topic of multicultural counseling training, Sue and Sue (2016) opine:

> "[S]ome students of color come to believe that multicultural training is only for White students; the implicit assumption is that they know the material already and are the experts on the subject … such a perspective prevents self-exploration and constitutes a form or resistance … people of color … are not immune from prejudice, bias, and discrimination …. Multicultural training is more than [dyads involving Whites vs. Non-Whites]. It is also about African American-Asian American, Asian American-Native American, and Latino/a-Native American relationships …. Race, culture, ethnicity, gender, and sexual orientation/identity are about everyone; it is not just a 'minority thing'." (p. 19)

Ongoing/Unresolved Controversies

As stated earlier, many scholars believe deeply in the construct validity of cultural competence and devote considerable effort conducting research in

hopes that they can improve on its shortcomings. Among those who hold this view, they identify key areas of controversy that remain unresolved to this day, which are briefly discussed below:

Controversies Over CC Definitions/ Measurement In the first half of this chapter, readers were exposed to analyses that made explicit the hidden assumptions that often are unstated in CC theory, for the purpose of showing them to be in error (which implies that cultural competency itself is a flawed construct). Kumaş-Tan et al. (2007) use the same analytic tools; however, their ultimate purpose is to argue that cultural competence theory and practice – while presently flawed – can be ultimately improved if audiences are willing to think more critically about its implicit assumptions. These authors identified the ten most frequently used cultural competence measures (at the time of their writing) used in counseling psychology, mental health counseling, nursing, and medicine. From a close examination of these measures, they identified six implicit assumptions that they regard as flawed and/or highly problematic:

1. *Culture is a matter of ethnicity and race*.
2. *Culture is possessed by the Other; the Other is/has the problem.*
3. *The problem of cultural incompetence lies in practitioners' lack of familiarity with the Other. Practitioners should be aware of, knowledgeable about, and seek contact with the Other.*
4. *The problem of cultural incompetence lies in practitioners' discriminatory attitudes toward the Other.*
5. *Cross-cultural healthcare is about Caucasian practitioners working with patients from ethnic and racialized minority groups.*
6. *Cultural competence is about being confident in oneself and comfortable with others.*

The authors advocate challenges to the underlying worldview that they see these assumptions as representing. They write:

> [W]e might reconsider a definition of culture that encompasses not only ethnicity and race, but also (at least) gender, age, income, education, sexual orientation, ability, and faith …. [W]e may need to … shift and expand what it is that we measure when evaluating cultural competence, … measure constructs above and beyond cultural competence in the traditional sense … develop more theoretically informed measures of effective practice across cultures, and/or … explore alternate methods for evaluating cultural competence, namely, qualitative and mixed methods. (p. 555)

Huey et al. (2014) propose a novel approach to rethinking how cultural competence is conceptualized and defined. This novel approach arises from the atheoretical "dust bowl empiricist" tradition (Nugent, 2013), which uses an inductive rather than deductive process to explicate important relationships in data. Here, they advocate defining cultural competence by first researching the factors that determine what makes some therapists effective with minority clients vs. those factors that cause therapists to be ineffective with minority clients. Survey and treatment process research would identify the personal characteristics and clinical skills that empirically differentiate these two groups. Writing about the relationship between caregiver cultural competence and patient outcomes within the healthcare field, Alizadeh and Chavan (2016) identify seven categories of outcomes that can serve as indicators of a clinician's cultural competence effectiveness: (1) increased numbers of patients seeking treatment, (2) lower rates of morbidity and mortality, (3) increased adherence to treatment, (4) higher levels of trust, (5) increased feelings of self-esteem, (6) improved health status, and (7) greater satisfaction with care.

Controversies in Research Pope-Davis et al. (2001) advocate for more research on culturally diverse clients' experiences with counselors. They argue that such research needs to "investigate the experiences of actual clients who have gone through therapy with a perceived multicultural counselor … to examine potential patterns in experiences" (p. 132). Pope-Davis et al. (2001) also advocate for more research in counselors' perceptions of their supervisor's cultural competence and how this may qualitatively impact the client/counselor relationship.

They argue in favor of using qualitative research methods, which would allow clients to describe their experiences in their own language. Qualitative research has the added advantage of allowing researchers to avoid the limitations of survey research (i.e., researcher biases, inability of surveys to capture key variables of interest to multicultural counseling).

Huey et al. (2014) offer the following suggestions for improving the design of research to better isolate and evaluate the specific effects of culturally competent practice. First, they recommend designing studies that would enable the researcher to clearly observe that the "culturally tailored" treatment leads to a significantly greater symptom reduction (or treatment engagement) than a generic treatment. The generic treatment should include the same core features as the culturally tailored treatment, yet not differ substantially in length or intensity.

Second, randomized controlled trials should have appropriate statistical power to detect effects from the cultural tailoring treatment. Third, the mechanisms hypothesized to account for cultural tailoring effects should be specified, tested, and confirmed by research. They justify this on the grounds that "cultural tailoring may enhance treatment effects, but not necessarily for the reasons theorized by investigators" (p. 322). Fourth, the authors argue that cultural adaptations and/or processes culled from research literatures outside of counseling and clinical psychology "could expand the range of treatment options for ethnic minorities" (p. 324).

Controversies in Training As observed in the History and Development of Cultural Competence Advocacy chapter, cultural competence self-report scales are an established fixture in much CC research. However, Jones, Sander, and Booker (2013) advise *against* using MCC self-report scales for evaluating trainee skills (p. 18). They state:

> Instead, we encourage the use of them for facilitating discussion, engaging in the process of self-reflection, and as an opportunity to learn more about your students to inform instruction or overall program development. In general, it is recommended that students be evaluated using a combination of evaluation methods for broad areas of professional development like cultural competence. (pp. 18–9)

Patterson (2004) argues that simple knowledge of different subgroups learned within a classroom setting is a necessary but insufficient method for developing cultural competence. Instead, it is argued that the best way to attain knowledge of a cultural group is to actually live within a community comprised of the kinds of clients with whom one expects to work.

Controversies Over Practice If the issue of cultural competence is set aside only momentarily, there exists a general agreement about the dearth of psychotherapy efficacy research with racial/ethnic minority clients (Lau et al., 2016). Nevertheless, there is a clear difference of opinion that can be identified in the literature as to the implications of this observation. One side opposes the practice of generalizing treatments to racial/ethnic minority populations in the absence of sufficient data. Those holding this view argue that this suggests a form of "cultural imperialism," in which the administration of treatments not validated on nonwhite groups should be accompanied by "warning labels" of limited external validity (Bernal & Scharrón-del-Río, 2001). Some have voiced concern that generalization of treatments that have not been sufficient validated on racial/ethnic minority groups may have the unwanted effect of reducing commitment to conduct necessary validation research on these groups (Sue & Zane, 2006).

In contrast, others argue that it would constitute a more serious error if insufficiently validated treatments were withheld from minority groups that could be helpful. Those who advocate for this position base this assertion on the following observations: (1) clinical evidence that evidence-based treatments can be used effectively with racial/ethnic minorities, (2) a small international literature on treatment outcomes, (3) a lack of evidence that evidence-based treatments are not effective for ethnic minorities, and (4) emerging findings that evidence-based treatments are effective for diverse samples (Lau et al., 2016; Miranda et al., 2003).

Returning to the issue of cultural competence, Stuart (2004) discusses 12 suggestions that, in his view, would help caregivers to "avoid stereotypes and identify the multiple cultural influences that often operate unconsciously in the mixed identities of most clients" (p. 6). These suggestions, coupled with a brief highlights within each, are adapted and outlined below:

1. *Develop skill in discovering each person's unique cultural outlook*. Here, clinicians are encouraged to develop ethnographic interviewing skills that would enable them to understand which specific aspects of clients' backgrounds are relevant to their own specific worldview.
2. *Acknowledge and control personal biases by articulating your worldview and evaluating its sources and validity*. Here, clinicians are encouraged to periodically evaluate their personal experiences about persons from a given racial/ethnic group with the research literature.
3. *Develop sensitivity to cultural differences without overemphasizing them*. The observation of a few stark differences between groups (however defined) should not be the basis for the gratuitous assumption that all other aspects about groups should be different as well.
4. *Uncouple theory from culture*. In understanding individuals, replace the broad category of "culture" with measurable psychological variables along which individuals differ.
5. *Develop a sufficiently complex set of cultural categories*. Since persons reflect far more diversity than is reflected in the language used by (academic) multiculturalists, it is more advisable to describe rather than categorize clients' identities.
6. *Critically evaluate the methods used to collect culturally relevant data before applying the findings in psychological services*. Researchers must define the population to which test/survey results will be generalized and make sure that the samples used to generalize are adequate in both size and representativeness.
7. *Develop a means of determining a person's acceptance of relevant cultural themes*. Clinicians are encouraged to use nuanced interviewing techniques to ascertain the extent to which specific "cultural" beliefs/practices are accepted, how strongly each is accepted, or whether or not particular beliefs are situation specific.
8. *Develop a means of determining the salience of ethnic identity for each client*. Demographic racial/ethnic categories may dominate, merely influence, or be utterly inconsequential with respect to a client's felt identity. "Sensitive" assessment involves asking clients to articulate the sources of their values/perspectives – which may involve many other factors related to developmental stage, gender, sexual orientation, religion, or nationality.
9. *Match psychological tests to client characteristics*. Great care must be taken to evaluate the appropriateness of instruments used in clinician/client interactions, and written reports must acknowledge any possible cultural bias that may impact findings.
10. *Contextualize all assessments*. Identify common environmental stresses experienced by members of racial/ethnic/cultural groups, and then consider the extent to which individual "traits" can or cannot be relabeled as coping responses.
11. *Consider clients' ethnic and worldviews in selecting therapists, intervention goals, and methods*. Intervention is not likely to succeed when it is offered by providers who do not earn clients' trust, use language or concepts that are not understood, or require behavioral or cognitive skills that clients lack. Careful matching of service providers and methods to clients' preferences and expectations helps to remove unnecessary obstacles to effective therapy, as well as enhances outcome.
12. *Respect clients' beliefs, but attempt to change them when necessary*. Empathetic caregivers see the world from the clients' perspective, but do not necessarily accept everything in the

client's view as healthy. There may be instances in which it is appropriate and/or ethical to change certain beliefs and/or behaviors.

In what is perhaps the most practical suggestion for improving cultural competence in practice, Huey et al. (2014) suggest that once culturally competent behaviors are reliably identified, researchers would do well to avoid requiring clinicians to use cultural competence protocols that involve "considerable training, complex protocols, extensive monitoring, substantial costs, and applicability only to narrow demographics" (p. 331). Instead, they advise the development and use of inexpensive, easy-to-adapt cultural competence protocols that "create minimal burden to mental health professionals" (p. 331).

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