In Search of Cultural Competence in Psychotherapy and Counseling

Stanley Sue
University of California, Davis

The characteristics involved in cultural competency in psychotherapy and counseling have been difficult to specify. This article describes attempts to study factors associated with cultural competency and addresses 3 questions. First, is ethnic match between therapists and clients associated with treatment outcomes? Second, do clients who use ethnic-specific services exhibit more favorable outcomes than those who use mainstream services? Third, is cognitive match between therapists and clients a predictor of outcomes? The research suggests that match is important in psychotherapy. The cultural competency research has also generated some controversy, and lessons learned from the controversy are discussed. Finally, it is suggested that important and orthogonal ingredients in cultural competency are therapists' scientific mindedness, dynamic-sizing skills, and culture-specific expertise.

Cultural competence is one of the most discussed concepts among scholars and practitioners interested in ethnic minority issues. Indeed, numerous groups at local and national levels have been examining the concept in trying to establish guidelines and standards for the provision of mental health services to ethnic minority populations, especially with the advent of managed care. Why is there such interest and enthusiasm? I believe that there is a growing realization that competent therapists and counselors must be cross-culturally competent. Because of the multiethnic nature of U.S. society and because of the increasingly frequent interactions Americans have with people from throughout the world, skills must be developed to effectively work with people from different cultures. Furthermore, cultural competency represents an important philosophical shift in defining ethnic and race relations, traditionally examined as a conflict involving assimilation versus pluralism.

The assimilation position was an ideology that culturally different groups should become incorporated into a largely Anglo mainstream. Gordon (1978) referred to this process as "Anglo-conformity," in which the desirability is assumed of maintaining the English language and English-oriented cultural patterns in American life. (An earlier notion, "the melting pot," sought cultural and biological merging but was less oriented toward Anglo-conformity.) Although some assimilation has occurred among the diverse groups in society, cultural and distinct ethnic group traditions have persisted in U.S. society as well as in many other societies. Assimilation has not progressed very far, especially in what Gordon conceptualized as "structural assimilation," that is, the systematic inclusion of ethnics in the White, Anglo-Saxon, Protestant social structure (cliques, churches, neighborhoods, home-visit patterns, etc.). In contrast to the assimilation position, those who advocated pluralism sought to recognize the ethnic and cultural integrity of different groups and the coexistence of groups in a pluralistic society. The concept of pluralism, attacked by assimilationists and melting-pot advocates, has also not fared well. Although there is recognition that different cultural groups exist in the United States, many in society fail to embrace pluralism as a desirable goal. Anti-immigration sentiments, the push for English-only materials, and so forth may reflect the opposition to pluralism.

Cultural competence (along with the broader concept of multiculturalism) is the belief that people should not only appreciate and recognize other cultural groups but also be able to effectively work with them. In a way, cultural competence is less controversial than assimilation and pluralism—how can one argue against competencies of any kind? And, whereas assimilation and pluralism are ideologies or philosophies of life, cultural competency is skill-based—skills that should be in the repertoire of all practicing psychologists (Hall, 1997). Given the interest in cultural competency, it is important to ask what the concept means. Is it old wine in new bottles?

In this article, I discuss (a) problems in mental health services, (b) attempts to study cultural competence over a period of about a decade, (c) policy issues arising

Editor's note. Articles based on APA award addresses are given special consideration in the *American Psychologist*'s editorial selection process.

A version of this article was originally presented as part of an Award for Distinguished Contribution to Research in Public Policy address at the 105th Annual Convention of the American Psychological Association, Chicago, IL, August 1997.

Author's note. I am grateful for the assistance of Karen Kurasaki and Shobha Srinivasan in providing me with constructive comments on an earlier version of this article.

Correspondence concerning this article should be addressed to Stanley Sue, Department of Psychology, University of California, Davis, One Shields Avenue, Davis, CA 95616-8686. Electronic mail may be sent to ssue@ucdavis.edu.

Copyright 1998 by the American Psychological Association, Inc. 0003-066X/98/$2.00
Vol. 53, No. 4, 440-448

from research, and (d) the meaning of cultural competence in psychotherapy and counseling. By "meaning," I am not referring to just its definition. The definition can be simply stated, that is, one is culturally competent when one possesses the cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture. Rather, I want to address the essence or character, namely, what constitutes cultural competence?

The Search for Cultural Competence

The impetus for cultural competence has been the inadequacy of services for members of ethnic minority groups such as African Americans, American Indians, Asian Americans, and Latinos. One of the most frequently cited problems in delivering mental health services to ethnic minority groups is the cultural and linguistic mismatches that occur between clients and providers (see Aponte, Rivers, & Wohl, 1995; Comas-Diaz & Griffith, 1988; Jenkins, 1985; LeVine & Padilla, 1980; Pope-Davis & Coleman, 1997; D. Sue, Ivey, & Pedersen, 1996; Trimble & LaFromboise, 1985). Cultural differences can affect the validity of assessment as well as the development of therapist–client rapport, the therapeutic alliance, and treatment effectiveness. Concerns regarding the problems in cross-cultural counseling and psychotherapy prompted the American Psychological Association (APA) to establish guidelines for the provision of psychological services to members of ethnic minority groups (APA Office of Ethnic Minority Affairs, 1993). The guidelines are largely hortatory in effect and implicitly recognize the difficulties in relationships between providers and clients.

In view of these problems, the investigators cited earlier made a series of recommendations to facilitate the provision of more culturally responsive treatments. The recommendations included the necessity to know the culture of clients, to be sensitive and flexible in dealing with clients, and to achieve credibility. It is interesting to note that the recommendations were not derived from definitive research findings but were based on theory involving cultural match or fit. That is, services should be delivered in ways that are consistent with the cultural background of clients. Indeed, in two major reviews (Chambless et al., 1996; S. Sue, Zane, & Young, 1994), not a single rigorous study examining the efficacy of treatment for any ethnic minority population was found. By "rigorous," I am referring to research in which (a) pre- and posttreatment outcomes are assessed for clients from one or more ethnic groups; (b) clients are randomly assigned to conditions, and control groups (e.g., no treatment, attention-placebo, or different ethnic groups matched on demographic characteristics other than ethnicity) are used when appropriate; (c) type of treatment and ethnicity are crossed when comparisons of outcomes by ethnicity and treatment are made; (d) multiple, culturally cross-validated assessment instruments are used; (e) outcomes are assessed over time; and (f) findings are replicated. Many of these criteria were used by the APA Division 12 Task Force on Psychological Interventions to evaluate empirically validated treatments (Chambless et al., 1996). Given the lack of solid research on treatment outcomes for ethnic minority populations, it is not surprising that the recommendations have been based on theory rather than research. Parenthetically, because of the lack of solid research, is it possible that ethnics are actually faring well in the mental health system? The available evidence suggests that this is not the case and that much can be done to improve the provision of mental health services to culturally diverse groups (S. Sue et al., 1994).

The Cultural Match Studies

Because of the lack of a solid research foundation, my colleagues and I decided to systematically study characteristics of cultural competence. Together with researchers at the National Research Center on Asian American Mental Health and a whole host of graduate students, we wanted to examine different facets of cultural competence. We were interested in three questions. First, when therapists and clients are of the same ethnicity, are treatment outcomes better than when therapists and clients differ in ethnicity? Over the years, the mental health professions have been criticized for not training more ethnic minority therapists who can serve their own communities. Is there evidence that ethnic clients benefit from seeing ethnically similar therapists? Under what conditions is ethnic match important? Match presumably may not be effective for everyone, so it is important to determine the conditions under which match is important. Second, when ethnic clients utilize ethnic-specific services, are outcomes better than if they utilize non-ethnic-specific or mainstream services? Many ethnic-specific services have been established throughout the country. Are these services effective, and what is it about such services that is effective? Third, when therapists and clients think in the same manner (i.e., exhibit cognitive match), regardless of their ethnicity, are treatment outcomes better?

I begin with the first question regarding ethnic match. Our study of ethnic match was based on thousands of African American, Asian American, Mexican American, and White clients seen in the Los Angeles County mental health system (S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991). The large data set enabled us to accomplish what other researchers had not done, namely, to report on large samples of different ethnic clients. The study was intended to examine length of treatment, dropout rates (after one session), and treatment outcomes (using pre- and posttreatment Global Assessment Scale [GAS] scores) as dependent measures. Specifically, we were interested in finding out if therapist–client matches in ethnicity and language were associated with attending more sessions, less dropping out, and more favorable treatment outcomes. Length of treatment was considered to be an important indicator of outcome because it is known to be directly related to favorable treatment outcomes (Orlinsky, Grawe, & Parks, 1994). Premature termination was examined because in my previous studies (see S. Sue, 1977), ethnic clients were found to drop out of treatment at a rate of about 50% after the initial treatment

session. In the ethnic match study, we controlled for a number of variables, including social class, initial level of functioning, gender, age, and so forth. Results indicated that Asian Americans—especially those who were unacculturated—generally fared better in terms of more sessions, less drop out, and better treatment outcomes when they saw a therapist who was matched ethnically, linguistically, or both. Similar effects were found for Mexican Americans, although the effects were less dramatic. Ethnic matches were significantly related to attending more sessions for African Americans and Whites; Whites also had lower rates of premature termination when they were ethnically matched, although match was not associated with premature termination among African Americans. When the results for number of sessions or premature termination were statistically significant, most of the effect sizes were large, indicating the clinical significance of the findings.

Finally, treatment outcomes for African Americans and Whites were not related to ethnic match. It is not known why matching is related to outcomes for some groups but not others. Perhaps, in this study (S. Sue et al., 1991), the outcome measure—GAS—lacked sufficient sensitivity to assess outcomes in a valid fashion. Therapists provided subjective ratings on a 100-point scale of the level of functioning of clients, and much variability may have existed in the validity of the ratings given by the numerous therapists. Alternatively, the importance of ethnic match may heavily depend on the acculturation level, ethnic–cultural identity, or ethnicity of clients. For some clients in the same ethnic minority group, match may be quite important. It is known that ethnic or language matches do not ensure cultural matches, which may be of major importance. That is, ethnicity is more of a demographic variable than a psychological variable. The psychological aspects (e.g., identity, attitudes, beliefs, and personality) may be of greater importance.

My colleagues and I also examined the outcomes of ethnic minority clients who used either ethnic-specific services or mainstream services (Takeuchi, Sue, & Yeh, 1995; Yeh, Takeuchi, & Sue, 1994). Ethnic-specific services are those that have a large ethnic clientele and presumably try to respond to the cultural needs of clients. They may respond by improving the accessibility of services to ethnic minorities (e.g., by providing flexible hours or placing treatment facilities in ethnic communities) and employing bicultural–bilingual staff. Various practices (e.g., ways of greeting clients) or arrangements (e.g., serving tea rather than coffee to Chinese clients) may be used that are congruent with the cultural background of clients. Ethnic-specific services may also mean that therapeutic practices are modified or developed so that the cultural customs, values, and beliefs of clients are considered (including in treatment indigenous healers or religious leaders in the community, increasing participation of family members, etc.).

To study ethnic-specific services, we (Takeuchi et al., 1995; Yeh et al., 1994) again examined the return rates, length of treatment, and treatment outcomes of ethnic minority adults. This time, however, African American, Asian American, and Mexican American clients were divided into those who received services from ethnic-specific programs and those who attended mainstream programs. Predictor variables included type of program (ethnic-specific vs. mainstream), severity of disorder, gender, age, social class, and ethnic match (whether or not clients had a therapist of the same ethnicity). This last variable, ethnic match, was important to enter as a predictor to distinguish the effects of service match from ethnic match. The results indicated that ethnic clients who attended ethnic-specific programs had lower dropout rates and stayed in the programs longer than did those using mainstream services. The findings were not clear-cut when treatment outcomes were examined. That is, treatment outcomes, as measured by the GAS, failed to show consistent or significant differences. However, the fact that ethnic-specific services were associated with lower dropout rates is important. As discussed earlier, a great deal of concern has been generated over the tendency for ethnic minority clients to prematurely drop out of treatment and to attend, on average, fewer treatment sessions (S. Sue, 1977), especially because treatment outcome has consistently demonstrated a direct relationship with the number of sessions in treatment (Orlinsky et al., 1994). The fact that clients stay in treatment longer may mirror the greater rapport, comfort, or cultural consistency of ethnic-specific services.

It should be noted that in investigations of ethnic match and ethnic-specific services match, the processes that account for the results are unknown. Why is ethnic match beneficial? Why do clients stay in treatment longer when using ethnic-specific services? Unfortunately, my colleagues and I could not randomly assign clients to therapists or services, and we could not directly examine process variables. However, it is noteworthy that the empirical results suggest that cultural match and treatment outcomes are related, a relationship hypothesized for many years by numerous ethnic practitioners and researchers.

In our search to define cultural competence, my colleagues and I have tried to study variables at a more micro level than for ethnic or services match. At the micro level, our interest was in cognitive match, that is, whether therapist–client similarity in thinking is associated with better treatment outcomes. Therapists and clients often have different explanatory models for clients' problems in terms of etiology, symptom meaning, course, and appropriate treatment (Kleinman, 1980). S. Sue and Zane (1987) argued that therapist–client differences in cultural attitudes and beliefs affect the process and efficacy of psychotherapy. We wanted to see if matches between therapists and clients in how they conceptualized goals for treatment and means for resolving problems would be more beneficial than mismatches. We also examined the match between therapists and clients in levels of acculturation. Measures of therapists' and clients' beliefs regarding goals for treatment, preferred means for resolving problems, and acculturation were collected at

a mental health center in San Francisco. The degree of match between therapists and clients was then used as a predictor of posttreatment symptoms, adjustment, and clients' ratings of the treatment sessions, after controlling for pretreatment status.

In view of the large numbers of analyses for the numerous criterion measures and their subscales, I provide a summary of the results that are currently still being analyzed. There is evidence that match is significantly related to treatment outcome and clients' perceptions of the sessions. In various comparisons, therapist–client matches on goals for treatment and on coping styles were related to better adjustment and more favorable impressions of the sessions. In no case did a cognitive mismatch predict better outcome. This study is important because it demonstrates that therapists' conceptions and their congruence with those of clients are related to therapeutic outcomes. An additional finding is that within-group differences were associated with acculturation levels of clients and therapists. Whereas our previous studies (S. Sue et al., 1991; Takeuchi et al., 1995) showed that ethnic match is important, we now have additional knowledge about the conditions that are related to favorable outcomes within ethnic match, that is, cognitive match.

The findings from this research should not be very surprising. As noted earlier, a number of investigators have argued that ethnic match and cognitive match are important. The significant point is that now there is empirical support for these arguments. The findings also suggest that there is a need to increase the ethnic diversity of service providers and to train therapists to understand the worldviews of their clients. Obviously, if clients' cultural beliefs radically differ from those of their therapists, rapport in treatment and treatment outcomes may be affected.

Dilemmas in Cultural Competence Research

In my search for cultural competency, I have been confronted with several dilemmas (S. Sue, 1992, 1995). The dilemmas are important to reveal because they illustrate the problems and misunderstandings that arise in ethnic–racial research. I review some of them and address the implications for policy and practice.

First, in psychology, there is growing interest in basing interventions on findings from rigorously conducted, empirical research because the practice of psychology has proceeded with insufficient guidance from or adherence to research findings (Dawes, 1995). Yet, in the case of ethnic minority populations, no rigorous research has determined if psychotherapy is effective. If therapists need to base practice on research findings, and if psychotherapy and assessment tools have not demonstrated their effectiveness or validity, should psychotherapy continue to be offered to these populations? How can guidelines and standards for cultural competency be devised in the absence of research? I believe that service providers must continue offering professional services to ethnic populations and use therapists' best and collective judgment in organizing services. There is substantial evidence that mental health needs among ethnic minority populations are substantial (Aponte & Crouch, 1995; President's Commission on Mental Health, 1978), and the mental health profession simply cannot wait for research to provide definitive answers. Similarly, one of the significant questions to address is why more research and more rigorous research has not been conducted on ethnic minority populations.

Second, the issue of segregation has been raised in some of my work. In the past, I recommended that specific services be created, targeting ethnic minority populations. This recommendation seemed to make sense because in communities with large ethnic populations, mental health services should focus on these populations by tailoring services—having bilingual–bicultural service providers, a culturally familiar environment, notices and announcements written in the ethnic language of the clients, and so on. Would having ethnic-specific services encourage segregation in that various ethnic groups would have services catering to their own group needs? Kramer (1984) opposed ethnic-specific services precisely because of his belief that segregation would be perpetuated. Would this relieve the responsibility for mainstream services (i.e., those not specifically designed for an ethnic minority group) to provide for ethnic minority groups? In principle, I agreed with the need for integrated services. However, at the time, integration of services did not seem likely in the near future because of ethnic patterns of residential segregation. Furthermore, the tailoring of services to particular ethnic groups appeared to be wise because these groups have been underserved or inappropriately served in the mental health system (President's Commission on Mental Health, 1978; Rogler, Malgady, & Rodriguez, 1989). This tailoring was not intended to relieve mainstream services from providing services to ethnic clients; rather, it was meant to complement existing services.

Third, ethnic matching of therapists and clients has also raised the issue of segregation. As mentioned earlier, my research (S. Sue et al., 1991) examined the effects of ethnic similarity–dissimilarity between clients and therapists in psychotherapy. The research findings indicated that African American, American Indian, Asian American, Mexican American, and White clients had lower premature termination rates, a greater number of sessions, or better treatment outcomes when matched with ethnically similar therapists. I suggested that ethnic similarity is beneficial for many clients and that the recruitment and training of therapists to serve their own ethnic populations should be encouraged. This suggestion proved to be a source of controversy. During a talk I gave at the 1994 Congress meeting of the International Association of Applied Psychology in Spain (S. Sue, 1994), a member of the audience informed me that some individuals in South Africa were using my research to justify segregation, that is, having Whites taking care of Whites and Blacks taking care of Blacks.

Although researchers often bemoan the fact that their research is not used for applied purposes or policies, my colleagues and I had the very opposite reaction. The

research was used. Advocates of certain policy agendas used our research findings in ways that we never anticipated. The research findings were not intended to be used to argue that clients should be ethnically matched. Rather, we wanted to find out if ethnic matching was associated with positive outcomes. We would then be in a position to examine what about match could account for the findings. Furthermore, individual differences in the effects of match appear to be very important, so that match is neither a necessary nor a sufficient condition for positive treatment outcomes. In other words, match may be important for some, but not all, clients. Ethnic diversity among service providers was essential because it allowed clients from minority groups the choice to find providers of the same ethnicity.

Fourth, another example of how ethnic mental health research has been used for purposes unanticipated by my colleagues and me occurred from some earlier work (S. Sue, 1977) that we conducted from data supplied by the state of Washington. In that National Institute of Mental Health (NIMH)-funded research project, we wanted to see how ethnic minority clients were faring in the mental health system. We found that more than 50% of the ethnic minority clients (African Americans, American Indians, Asian Americans, and Mexican Americans) at the 17 community mental health facilities in Seattle–King County terminated treatment after one session, compared with the 30% dropout rate for Whites. We concluded that ethnic clients were not being well served by the system. Unknown to us, when NIMH became aware of our findings, it contacted the Washington State Department of Social and Health Services (DSHS) to express its deep concern over the plight of ethnic minority mental health clients. NIMH essentially used our findings to point out that the state was not in compliance with standards to provide quality services to all groups. Fearing that the state might suffer adverse public reaction because of the study's results and that future funding from NIMH might be jeopardized, DSHS then challenged the validity of our findings. It claimed that 1 of the 17 mental health centers, which contained a high proportion of ethnic clients, might not have provided valid data.

We decided to reanalyze the data, excluding the one mental health center in question. The findings remained the same. Yet, we were not happy over the situation for several reasons. First, we felt torn between the need to understand the nature of the problems in our mental health system (which would enable us to find means for resolving these problems) and the need to commend the state for its openness and support for the research. Second, we and the state did not know that the research would be used for compliance purposes; I was worried that in the future local and state governmental agencies might be reluctant to provide data to researchers for fear that the findings might have negative consequences for the agencies. Third, although I was pleased with the fact that NIMH demonstrated a determination to see that all clients are able to receive effective treatment, I was also concerned that the state of Washington was being singled out for criticism when other states were experiencing similar difficulties in the provision of services to ethnic clients. Because of the controversy, I was asked by the Washington State Psychological Association to testify at a Senate subcommittee hearing concerning the entire matter. Fortunately, some positive outcomes emerged after my testimony. Officials from the state indicated their genuine concern over the delivery of services to all clients and their willingness to collaborate on research in the future. In addition, over the years, the state made some innovative changes in the mental health system to offer culturally responsive services. In a 10-year follow-up investigation of the Seattle project, O'Sullivan, Peterson, Cox, and Kirkeby (1989) found that the high dropout rates for ethnic minority clients had been reduced and that the mental health system had hired more ethnic minority service providers, created more ethnic-specific services, and established other programs to serve ethnic clients.

Fifth, S. Sue et al.'s (1991) study demonstrated that dropout rates are reduced and the number of treatment sessions is increased when clients see ethnically similar therapists. However, given managed care guidelines, in which short-term treatment is preferred, what will these findings mean? That is, because ethnic similarity between clients and therapists is associated with longer treatment, under managed care ethnic similarity may pose problems, for example, the greater the number of sessions, the costlier the treatment. Therefore, the association between ethnic match and increased number of treatment sessions can be used to argue against matching because match appears to increase the cost of treatment. This is a particular problem because superior outcomes for ethnically matched dyads could not be unequivocally demonstrated from the match studies.

Lessons Learned From the Research

What lessons have been learned? The dilemmas that have accompanied the work illustrate the possibility that in conducting ethnic research, investigators are likely to encounter the issues and conflicts that have bedeviled U.S. society with respect to ethnic and race relations. That is, race relations have always generated considerable emotional reactions. Research into these issues will also engender many emotional responses. The emotional intensity in debates over ethnic research findings is typically much greater than that found in debates over, for example, depression research. This intensity is understandable. Many of the findings from ethnic research have implications for policies and practices and can support or challenge cherished personal values and beliefs. In this sense, ethnic minority research can be distinguished from cross-cultural research. In comparative cross-cultural research, evaluations and contrasts are made of people in different cultures (e.g., Chinese in China and Mexicans in Mexico). In comparative ethnic minority research, the evaluations and contrasts typically involve not only people with different cultural backgrounds but also those who have had years of interactions (e.g., African Americans and White Americans). Therefore, unlike cross-cultural re-

search, ethnic minority research must take into account the history of race–ethnic relations, prejudice, stereotyping, and discrimination, in addition to cultural differences (Jones, 1997; Watts, 1994). It is this history that makes ethnic minority research a volatile area of investigation.

Partly as a consequence of the potentially controversial nature of ethnic research or the practical, methodological, and conceptual problems in such research, investigators may be reluctant to study ethnicity. This is unfortunate because ethnic research is beneficial not only for ethnic individuals but also for all Americans and for science. As a case in point, having served on the APA Division 12 Task Force on Psychological Interventions, I sincerely appreciated the efforts to determine which treatments have empirical validation. However, as mentioned earlier, no rigorous studies have ever been conducted on the efficacy of treatment for members of ethnic minority groups. Why is there a paucity of research on the effectiveness of treatment with different client populations? How can treatments be designated as validated (i.e., where validity is attributed to the treatments) when cross-cultural–ethnic minority validity has never been established? In other words, it is precisely through the study of different populations that the validity and applicability of theories and practices can be ascertained.

Finally, in acknowledging the difficulties and dilemmas that are faced in ethnic research, psychology should be prepared to deal with the issues. The complexity of issues must be recognized, especially when research on ethnicity often has policy, practice, and value implications. Many actions that are based on research have intended or unintended side effects, so that practices may be beneficial at one level but harmful at another level. For example, ethnic match of therapists and clients can be viewed as either positive (i.e., reducing treatment dropout rates and increasing the number of treatment sessions) or negative (i.e., driving up the cost of treatment because of the increased number of sessions). Psychologists must begin to anticipate the consequences of research and practices because it may not be possible to avoid the side effects of programs and policies that are undertaken. In this way, conscious and deliberate decision making can be made that considers costs, benefits, principles, realities, values, and ultimate goals in a multiethnic society. It is through this process of deliberation that a more coherent approach to diversity can emerge.

Researchers have made progress on determining the nature of cultural competency. Empirical research does support some of the arguments that ethnic researchers and practitioners have advanced over the years. However, findings have frequently raised controversies, and researchers must be aware of the implications of their work, including misuse of the findings. Many of the controversies reveal society's discomfort regarding issues of race and ethnicity.

Cultural Competency Ingredients

Research has provided some insights into the structural ingredients (ethnic, service, and cognitive match) that are associated with treatment outcomes. I now return to the basic issue of what cultural competence is. The simple definition is that cultural competence involves effectiveness in psychotherapy. However, what therapist characteristics or skills are important? Research has not provided much knowledge into this question or many other questions. If a person is culturally effective with one group, is that person a culturally competent therapist? Or does culturally competent mean that one is effective with more than one culturally distinct group? If one of the characteristics of cultural competency is knowing the cultures of groups, and if it is impossible to really know the cultures of all groups in society, can one ever be truly culturally competent?

Perhaps the reason for the existence of these questions is that investigators have not in a clear fashion conceptually distinguished between general skills that promote cultural competency and specific skills that enhance effectiveness in a particular culture. For example, just as a psychotherapist may be limited in effectively applying Western-based treatments to individuals from non-Western societies, a folk healer who is effective in his or her culture may be ineffective with people in Western cultures. There appear to be skills that enhance work across different cultural groups and skills that may be specific to particular groups. This is why researchers have had a very difficult time devising measures of cultural competency—because culture-specific skills rather than more general skills may be assessed, or visa versa. General and specific skills need to be considered.

I would like to advance several propositions in trying to uncover the essence of cultural competency. First, three characteristics are critical in cultural competency: (a) being scientifically minded, (b) having skills in dynamic sizing, and (c) being proficient with a particular cultural group. Second, these characteristics are orthogonal in that it is possible to be proficient in none, one, two, or all of them. Third, there are degrees of cultural competency, and to adequately measure it, all three characteristics must be considered.

Scientific Mindedness

There probably are some skills that are beneficial to have in cultural competency—characteristics or skills that cut across cultures. Although examples can be found where some time-honored skills, such an being an empathic therapist or a good listener, may not be culturally appropriate, on the whole, there are some characteristics that are important to possess.

I believe one of these characteristics is scientific mindedness. By scientific mindedness, I am referring to therapists who form hypotheses rather than make premature conclusions about the status of culturally different clients, who develop creative ways to test hypotheses, and who act on the basis of acquired data. In cross-cultural relationships, many mistakes happen because assumptions are made or theories are applied that are developed in one culture and applied to clients from different cultures. The assumptions are based on erroneous beliefs

that clients' processes or dynamics are the same across different cultures, a phenomenon labeled the "myth of sameness" (Wilson, Phillip, Kohn, & Currey-El, 1995). By forming hypotheses rather than using the sameness myth, therapists can then test their clinical inferences. For example, a client who reports seeing spirits may be experiencing a common cultural hallucination rather than a psychotic episode. A good clinician who is uncertain of the cultural meaning of the symptom should engage in hypothesis testing: For example, if the symptom is a reflection of a psychotic episode rather than a culturally influenced characteristic, one would expect (a) the client to manifest other psychotic symptoms, (b) other individuals in the culture to be unfamiliar with the symptom, or (c) experts in the culture to indicate that the symptom is unusual in that culture. Ridley (1995) noted that African American clients exhibiting paranoia in the presence of a therapist may be doing so because of a healthy or unhealthy condition. Because of experiences with racism, those who show discomfort and lack of self-disclosure with a White therapist may have a nonpathological reaction (cultural paranoia). In this case, Ridley hypothesized that the reaction is confined to a White therapist and not an African American therapist. A pathological condition is functional paranoia, in which self-disclosure is not made to any therapist regardless of race. The point is that culturally competent therapists will try to devise means of testing hypotheses about their clients. This scientific mindedness may also help to free therapists from ethnocentric biases or theories.

Dynamic Sizing

The second characteristic is dynamic sizing—a phrase used in computer circles to indicate a fluctuating cache size. I use it to mean that the therapist has appropriate skills in knowing when to generalize and be inclusive and when to individualize and be exclusive. That is, the therapist can flexibly generalize in a valid manner. One of the major difficulties in interpersonal and interracial or interethnic relationships is the stereotyping of members of a group (Jones, 1997). Although therapists may avoid the overt expression of stereotypes (e.g., beliefs that African Americans are lazy, Chinese are shy, Mexican Americans are family-oriented), stereotypes may, nevertheless, exist in their belief systems and affect their behaviors. In such stereotypes, the individual's characteristics are confounded with the characteristics attributed to the group. In contrast, the opposite mistake can be made, such as ignoring cultural group characteristics that may be affecting that individual. Prejudices, stereotypes, and failures to consider culture among therapists or service providers are frequently no different from those found among the general population.

Appropriate dynamic sizing is a critical part of cultural competency. It allows one to avoid stereotypes of members of a group while still appreciating the importance of culture. The concept is similar to the notion of "flex" proposed by Ramirez (1991). In flex, individuals can learn how to switch cognitive styles (e.g., field dependence and independence) to more accurately deal with the environment. In dynamic sizing, the therapist is able to place the client in a proper context—whether that client has characteristics typical of, or idiosyncratic to, the client's cultural group. Moreover, there is another important component of dynamic sizing that involves the ability to appropriately generalize one's own experiences. For example, a person who has experienced discrimination and prejudice as a member of one group may be able to understand the plight of those in another group who encounter the same experiences. An African American who has faced oppression may be able to more easily understand the feelings of women who are oppressed. All people have felt like outsiders at one time or another. If this experience can be used to understand the feelings of many minority group persons, then therapists can become more empathetic and understanding and better clinicians. They are able to see and understand common experiences. However, the mere fact that therapists have experiences as, for example, an outsider, does not guarantee the ability to empathize. The ability to dynamically size—to appropriately categorize experiences—is important.

Culture-Specific Elements

The third characteristic is culture-specific expertise. Different cultures may have culture-specific experts—shamans, witch doctors, fortune-tellers, acupuncturists, folk healers, and so forth. These experts presumably are effective in their own cultures because they know the cultures and have the skills to translate this knowledge into effective interventions. Culturally skilled helping professionals have good knowledge and understanding of their own worldviews, have specific knowledge of the cultural groups with which they work, understand sociopolitical influences, and possess specific skills (intervention techniques and strategies) needed in working with culturally different groups. These helping professionals also are able to use culturally based interventions and have the ability to translate interventions into culturally consistent strategies. These characteristics have been extensively discussed in the literature as being important in effective psychotherapy and counseling with members of minority groups (see Chin, De La Cancela, & Jenkins, 1993; Helms & Richardson, 1997; Lee, 1996; Paniagua, 1994; Parham, 1996; Root, 1985; D. Sue et al., 1996).

The three characteristics—scientific mindedness, dynamic sizing, and culture-specific expertise—are orthogonal. That is, the three are independent. It is possible to be scientific minded and yet naive about the cultural background of the client (i.e., have good general skills but no knowledge of the culture of a particular client); to be able to appropriately generalize and individualize and yet fail to engage in hypothesis testing; and to understand and work effectively in a particular culture and yet use stereotypes of individuals in another culture.

Although it would be desirable to have the three characteristics, most therapists vary in the degree to which each characteristic is possessed. Scientific mindedness and dynamic sizing provide clinicians with gen-

eral tools that can be carried from one cultural client or situation to another. They provide a modus operandi. For example, using the skills associated with scientific mindedness, a clinician seeing a client from Culture *X* might reflect as follows:

I am unfamiliar with Culture *X*. Therefore, in working with the client, I first have to address a number of basic questions. For example, how proficient is the client with English? How acculturated is the client, and how familiar is the client with psychotherapy? Will there be communication difficulties? How will I assess the client? What does the client think of me and of treatment? I next have to form hypotheses, test the hypotheses, and then modify my behaviors in accordance with the findings.

In dynamic sizing, the therapist treating the client from Culture *X* might consider the following questions: What are my stereotypes or impressions of the client and the client's culture? How typical is the client of the culture? What might the client be thinking or feeling as a member of that culture? As in the case of scientific mindedness, dynamic sizing is a general tool that can be applied from client to client. The tools force therapists to systematically consider issues that therapists typically ignore or erroneously assume to know the answers. They can be used with all clients but are especially helpful with those who come from cultures different than that of the therapist.

When researchers try to measure cultural competence, they should not be confined just to the knowledge that they have about a particular culture. Rather, researchers also have to assess general skills such as scientific mindedness and dynamic-sizing abilities. I believe that they are among the most important characteristics that define cultural competency.

In summary, I have tried to reflect on experiences that my colleagues and I have had in the search for cultural competency. Our empirical research has largely supported the importance of phenomena that other researchers and professionals have proposed as being critical in cultural competence, namely, ethnic match, service match, and cognitive match. In following this line of research, I have encountered many policy and political issues that have made me aware of the need to constantly indicate the meaning and limitations of my findings. In the course of my research, I have come to the opinion that three independent characteristics involving scientific mindedness, dynamic sizing, and culture-specific expertise are important in cultural competence.

REFERENCES

APA Office of Ethnic Minority Affairs. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist, 48,* 45–48.

Aponte, J. F., & Crouch, R. T. (1995). The changing ethnic profile of the United States. In J. F. Aponte, R. Y. Rivers, & J. Wohl (Eds.), *Psychological interventions and cultural diversity* (pp. 1–18). Boston: Allyn & Bacon.

Aponte, J. F., Rivers, R. Y., & Wohl, J. (Eds.). (1995). *Psychological interventions and cultural diversity.* Boston: Allyn & Bacon.

Chambless, D. L., Sanderson, W. C., Shoham, V., Bennett-Johnson, S., Pope, K. S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A., & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49,* 5–18.

Chin, J. L., De La Cancela, V., & Jenkins, Y. M. (1993). *Diversity in psychotherapy.* Westport, CT: Praeger.

Comas-Diaz, L., & Griffith, E. E. (Eds.). (1988). *Clinical guidelines in cross-cultural mental health.* New York: Wiley.

Dawes, R. M. (1995). Standards of practice. In S. C. Hayes, V. M. Follette, R. M. Dawes, & K. E. Grady (Eds.), *Scientific standards of psychological practice: Issues and recommendations* (pp. 31–43). Reno, NV: Content Press.

Gordon, M. M. (1978). *Human nature, class, and ethnicity.* New York: Oxford University Press.

Hall, C. C. I. (1997). Cultural malpractice: The growing obsolescence of psychology with the changing U.S. population. *American Psychologist, 52,* 642–651.

Helms, J. E., & Richardson, T. Q. (1997). How "multiculturalism" obscures race and culture as differential aspects of counseling competency. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education and training, and supervision* (pp. 60–82). Thousand Oaks, CA: Sage.

Jenkins, A. H. (1985). Attending to self-activity in the Afro-American client. *Psychotherapy, 22,* 335–341.

Jones, J. M. (1997). *Prejudice and racism.* San Francisco: McGraw-Hill.

Kleinman, A. (1980). *Patients and healers in the context of culture.* Berkeley: University of California Press.

Kramer, B. M. (1984). Community mental health in a dual society. In S. Sue & T. Moore (Eds.), *The pluralistic society: A community mental health perspective* (pp. 254–262). New York: Human Sciences Press.

Lee, C. C. (1996). MCT theory and implications for indigenous healing. In D. W. Sue, A. E. Ivey, & P. B. Pedersen (Eds.), *A theory of multicultural counseling and therapy* (pp. 88–98). San Francisco: Brooks/Cole.

LeVine, E. S., & Padilla, A. M. (1980). *Crossing cultures in therapy: Pluralistic counseling for the Hispanic.* Monterey, CA: Brooks/Cole.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy—noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–378). New York: Wiley.

O'Sullivan, M. J., Peterson, P. D., Cox, G. B., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology, 17,* 17–30.

Paniagua, F. A. (1994). *Assessing and treating culturally diverse clients.* Thousand Oaks, CA: Sage.

Parham, T. (1996). MCT theory and African-American populations. In D. W. Sue, A. E. Ivey, & P. B. Pedersen, *A theory of multicultural counseling and therapy* (pp. 177–191). San Francisco: Brooks/Cole.

Pope-Davis, D. B., & Coleman, H. L. K. (Eds.). (1997). *Multicul... counseling competencies: Assessment, education and training, and supervision.* Thousand Oaks, CA: Sage.

President's Commission on Mental Health. (1978). *Report to the President.* Washington, DC: U.S. Government Printing Office.

Ramirez, M. (1991). *Psychotherapy and counseling with minorities: A cognitive approach to individual and cultural differences.* New York: Pergamon Press.

Ridley, C. R. (1995). *Overcoming unintentional racism in counseling and therapy.* Thousand Oaks, CA: Sage.

Rogler, L. H., Malgady, R. G., & Rodriguez, O. (1989). *Hispanics and mental health: A framework for research.* Malabar, FL: Krieger.

Root, M. (1985). Guidelines for facilitating therapy with Asian American clients. *Psychotherapy, 22,* 349–356.

Sue, D. W., Ivey, A. E., & Pedersen, P. B. (Eds.). (1996). *A theory of multicultural counseling and therapy.* San Francisco: Brooks/Cole.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32,* 616–624.

Sue, S. (1992). Ethnicity and mental health: Research and policy issues. *Journal of Social Issues, 48,* 187–205.

Sue, S. (1994, July). *Delivering mental health services in multicultural societies.* Paper presented at the meeting of the International Association of Applied Psychology, Madrid, Spain.

Sue, S. (1995). The implications of diversity for scientific standards of practice. In S. C. Hayes, V. M. Follette, R. M. Dawes, & K. E. Grady (Eds.), *Scientific standards of psychological practice: Issues and recommendations* (pp. 265–279). Reno, NV: Content Press.

Sue, S., Fujino, D., Hu, L., Takeuchi, D., & Zane, N. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Clinical and Consulting Psychology, 59,* 533–540.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42,* 37–45.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 783–820). New York: Wiley.

Takeuchi, D. T., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health, 85,* 638–643.

Trimble, J. E., & LaFromboise, T. (1985). American Indians and the counseling process: Culture, adaptation, and style. In P. B. Pedersen (Ed.), *Handbook of cross-cultural counseling and therapy* (pp. 127–134). Westport, CT: Greenwood.

Watts, R. J. (1994). Paradigms of diversity. In E. J. Trickett, R. J. Watts, & D. Berman (Eds.), *Human diversity: Perspectives on people in context* (pp. 49–80). San Francisco: Jossey-Bass.

Wilson, M. N., Phillip, D., Kohn, L. P., & Curry-El, J. A. (1995). Cultural relativistic approach toward ethnic minorities in family therapy. In J. F. Aponte, R. Y. Rivers, & J. Wohl (Eds.), *Psychological interventions and cultural diversity* (pp. 92–108). Boston: Allyn & Bacon.

Yeh, M., Takeuchi, D. T., & Sue, S. (1994). Asian American children in the mental health system: A comparison of parallel and mainstream outpatient service centers. *Journal of Clinical Child Psychology, 23,* 5–12.