Multicultural Competence: Criteria and Case Examples

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How do you as a professional psychologist know if you are competent to treat clients whose cultural origins and values differ from your own? What awareness, knowledge, and skills do you need? With whom should you consult? When should you refer? Adopting an idiographic, inclusive approach, the authors identify 12 minimal multicultural competencies for practice and illustrate their usefulness through 3 case examples. Suggestions for how professional psychologists can augment and evaluate their own multicultural competencies are offered as well as implications for professional psychology educators.

Consider the following scenario: Dr. Mary Ann Smith is a European American licensed clinical psychologist trying to build her private practice in a medium-sized town in the upper Midwest. She has worked to become listed on provider panels and realizes how important self-referred individuals with good insurance are to her livelihood. In 1 week, she receives three new clients: a recently fired Native American male nurse filing a discrimination lawsuit against the school district; a Spanish-speaking Mexican American lesbian fighting a custody battle with her ex-husband; and a blind, indigent, 70-year-old Irish American man with depression. "Am I competent to treat these clients?" wonders Dr. Smith, "and if not, to whom do I refer?"

For professional psychologists like Dr. Smith, working with diverse clients will soon become the norm rather than the exception. Shortly after the year 2050, racial and ethnic minorities will become a numerical majority in the United States (U.S. Bureau of the Census, 1995). Nearly 75% of the current entering labor force are racial and ethnic minorities or women, and when "baby

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boomers" begin to retire, more than 50% of those contributing to social security and pension plans will be racial and ethnic minorities (Sue, Arredondo, & McDavis, 1992). These examples cover only 3 of the 10 identified groups specified in the ethics code of the American Psychological Association (APA, 1992; e.g., age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status). Hence, very soon, probably at least 50% of all clients will identify with the disenfranchised segment of one or more of these groups. Thus, Dr. Smith's situation described above is not at all unique.

Numerous authors have argued that traditional psychology approaches and techniques are ineffective when they minimize or ignore the importance of such variables as age, gender, ethnicity, sexual orientation, and disability (e.g., Casas, Ponterotto, & Gutierrez, 1986; Enns, 1997; Malgady, 1996; Olkin, 1999; Perez, DeBord, & Bieschke, 1999). As a result, an assessment and treatment literature has emerged with specific considerations for clients from particular groups (e.g., APA Working Group on the Older Adult, 1998; Aponte, Rivers, & Wohl, 1995; Atkinson & Hackett, 1995; Casas, 1995; Dana, 1993; Enns, 1997; Fassinger & Richie, 1997; McGoldrick, Giordano, & Pearce, 1996; Olkin, 1999; Pedersen, Draguns, Lonner, & Trimble, 1996; Perez et al., 1999).

The APA (1992) ethics code, the *Guidelines and Principles for Accreditation of Programs in Professional Psychology* (APA, 1996a), and the "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations" (APA, 1993) recommend or require that psychologists develop cultural competencies. Standard 1.08 (APA, 1992) mandates that psychologists, when working with members of identified groups, "obtain the training, experience, consultation, or supervision *necessary to ensure the competence* of their services" (p. 1601, emphasis added). Standard 1.10 prohibits unfair discrimination, and Standard 2.04 requires adjustments in diagnoses and predictions and in the administration and interpretation of psychological assessments based on factors related to "gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status" (APA, 1992, p. 1603).

The challenge for the individual practicing professional psychologist (and, indirectly, for organized psychology) is what level of awareness, knowledge, and functioning meets these expectations? Our position is that clinicians such as Dr. Smith who might

be tempted to rely solely on their empathic skills and their diverse clients to learn about relevant cultural considerations are, in all likelihood, not practicing competently. As the remainder of this article illustrates, competence requires more than goodwill, minimal exposure to multicultural issues in graduate school, or several continuing education workshops.

In a survey of recent clinical and counseling psychology graduates, 70% had attended postdoctoral seminars on diversity issues (Allison, Crawford, Echemendia, Robinson, & Knepp, 1994). The authors also reported troubling discrepancies between the percentage of respondents serving diverse clients (e.g., 56% for African American clients) and their level of competence in doing so (e.g., 38% felt extremely or very competent). For only 3 of the 13 cultural groups listed (i.e., European Americans, women, and economically disadvantaged individuals) did more than 50% of the respondents report feeling extremely or very competent. Furthermore, only one quarter of those surveyed had taken a graduate course on multicultural counseling, and nearly one half of respondents indicated supervision of their therapy cases "never" or "infrequently" addressed cultural issues. In another study (Ladany, Inman, Constantine, & Hofheinz, 1997), no relationship was found between coder-rated multicultural case conceptualization skills and the completion of a multicultural graduate course or the amount of professional experience with ethnically diverse clients. Both studies underscore Myers, Echemendia, and Trimble's (1991) earlier estimation that the average new professional psychology graduate may be only slightly more competent to meet the mental health needs of culturally diverse individuals than are psychologists who completed their training 20 years ago.

The option of simply referring all clients with whom we are culturally dissimilar has never worked. Considering ethnicity alone, there are too few practicing ethnic minority professional psychologists (5.6%; Peterson et al., 1998) to accommodate the increasing number of diverse clients. Thus, European American psychologists like Dr. Smith must assume primary responsibility for providing competent services to diverse clients (Bernal & Castro, 1994).

Despite calls for greater explication of specific minimal competencies (APA, 1996b; Bernal & Castro, 1994; Quintana & Bernal, 1995), Pope-Davis, Reynolds, Dings, and Nielson (1995) concluded that "there is little agreement as to what constitutes multicultural competencies" (p. 323). No wonder professional psychologists are uncertain about what constitutes an acceptable standard of care. Training programs, internship sites, and the profession of psychology overall need to do a better job of defining and ensuring multicultural competence for established professional psychologists and students. Toward this end, in this article, we (a) explicate 12 minimum multicultural competencies for practice, (b) illustrate how these competencies guide and enhance treatment considerations through three case examples, and (c) discuss implications for practitioners and training programs.

Description of the 12 Practice Competencies

Prior to enumerating specific competencies, we developed the following precise definition of practice-related *multicultural competence:* (a) awareness and knowledge of how age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status are crucial dimensions to an informed professional understanding of human behavior and (b) clinical skills necessary to work effectively and ethically with culturally diverse individuals, groups, and communities. One important implication of this definition is that multicultural competency does not, as is often thought, encompass only the four primary ethnic minority groups in the United States: African Americans, Native Americans, Latinos–Latinas, and Asian Americans (Allison et al., 1994; Hays, 1995). Rather, it includes many of us—in one way or another. Furthermore, this definition assumes that there is always a dialectical relationship between understanding people as individuals and understanding them as representatives of all the groups with which they identify. Multicultural competence is finding some reasonable, responsible, and ethical balance among these factors—a balance that is likely to be different for each professional situation.

On the basis of a review of the literature, we initially identified 51 multicultural competencies related to research and practice domains for professional psychologists. We eventually distilled this list to 24 minimal competencies, and we report on the 12 practice-related ones in this article.

Table 1 lists these 12 competencies for independent professional practice, including suggested reference citations for each from the substantial existing knowledge base. The term *identified groups* refers to individuals who self-identify with 1 of more of the 10 dimensions specified in the APA (1992) ethics code (e.g., age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status). As an organizational tool, we adopted the widely cited tripartite conceptualization of awareness, knowledge, and skills (Pope-Davis et al., 1995; Sue et al., 1992). In general, we thought of awareness as a valuing dimension, knowledge as relevant information, and skills as acquired techniques for use in clinical practice. This list of 12 competencies is intended to clarify and extend previously developed lists (e.g., APA, 1993; Sue et al., 1992).

The awareness competency (Competency 1 in Table 1) taps one's own cultural heritage, gender, class, ethnic and racial identity, sexual orientation, disability, and age, along with how these characteristics shape one's values, assumptions, and biases related to others. This self-knowledge affects the psychologist's core beliefs, perceptions of what constitutes psychopathology and health, moment-to-moment clinical reactions, and a host of other variables. Awareness competencies are often assessed by using racial identity (Helms, 1995) and self-report multicultural competencies measures (Ponterotto, Rieger, Barrett, & Sparks, 1994). Graduate course work emphasizes this awareness dimension (Mintz, Bartels, & Rideout, 1995; Neville et al., 1996), with experiential exercises often used to heighten self-understanding.

The seven knowledge competencies involve such commonly cited areas as culture-specific diagnostic categories and assessment tools (Competencies 5 and 7); group-specific normative values about illness, help-seeking behavior, and interactional styles (Competency 6); and how family structures, gender roles, values, and worldviews differ across groups and how these affect personality formation, developmental outcomes, and manifestations of mental and physical illness (Competency 8). In addition, multiculturally competent professional psychologists should understand the extent of cultural and historical embeddedness of psychological theory and practice (Competency 2), as well as the effects of such issues

Table 1

Minimal Multicultural Competencies for Practice

1. Awareness of how one's own cultural heritage, gender, class, ethnic–racial identity, sexual orientation, disability, and age cohort help shape personal values, assumptions, and biases related to identified groups (e.g., Carter, 1995; Comas-Diaz & Greene, 1994; Enns, 1997; Helms, 1995; Kitayama & Markus, 1994; Olkin, 1999; Wrobel, 1993).

2. Knowledge of how psychological theory, methods of inquiry, and professional practices are historically and culturally embedded and how they have changed over time as societal values and political priorities shift (e.g., Betancourt & Lopez, 1993; Goldberger & Veroff, 1995; Prilleltensky, 1990).

3. Knowledge of the history and manifestation of oppression, prejudice, and discrimination in the United States and their psychological sequelae (e.g., APA, 1993; Betancourt & Lopez, 1993; Gaines & Reed, 1995; Perez et al., 1999).

4. Knowledge of sociopolitical influences (e.g., poverty, stereotyping, stigmatization, and marginalization) that impinge on the lives of identified groups (e.g., Landrine, 1995; Olkin, 1999; Perez-Foster, Moskowitz, & Javier, 1996).

5. Knowledge of culture-specific diagnostic categories (e.g., *Diagnostic and Statistical Manual of Mental Disorders* [4th ed.; American Psychiatric Association, 1994]; APA, 1993).

6. Knowledge of such issues as normative values about illness, help-seeking behavior, interactional styles, and worldview of the main groups that the clinician is likely to encounter professionally (e.g., Dana, 1993; McGoldrick et al., 1996; Price & McNeill, 1992).

7. Knowledge of culture-specific assessment procedures and tools (e.g., Dana, 1993) and their empirical support.

8. Knowledge of family structures, gender roles, values, beliefs, and worldviews and how they differ across identified groups in the United States, along with their impact on personality formation, developmental outcomes, and manifestations of mental and physical illness (e.g., APA, 1993; Draguns, 1997; Harwood, Miller, & Irizarry, 1995; Kagitcibasi, 1996; Kitayama & Markus, 1994; Kleinman, 1988; Lancy, 1996; Landrine, 1992; McGoldrick et al., 1996).

9. Ability to accurately evaluate emic (culture-specific) and etic (universal) hypotheses related to clients from identified groups and to develop accurate clinical conceptualizations, including awareness of when clinical issues involve cultural dimensions (APA, 1993) and when theoretical orientation needs to be adapted for more effective work with members of identified groups (e.g., APA, 1993; Hays, 1995; McGoldrick et al., 1996; Olkin, 1999; Ridley, Mendoza, & Kanitz, 1994).

10. Ability to accurately self-assess one's multicultural competence, including knowing when circumstances (e.g., personal biases; stage of ethnic identity; lack of requisite knowledge, skills, or language fluency; sociopolitical influences) are negatively influencing professional activities and adapting accordingly (e.g., obtaining needed information, consultation, or supervision or referring the client to a more qualified provider; e.g., APA, 1993; Enns, 1997; Olkin, 1999; Sue et al., 1992).

11. Ability to modify assessment tools and qualify conclusions appropriately (including empirical support, where available) for use with identified groups (Dana, 1993; Helms, 1992; Jones & Thorne, 1987; Kleinman, 1988; Malgady, 1996; Olkin, 1999; Sue et al., 1992).

12. Ability to design and implement nonbiased, effective treatment plans and interventions for clients from identified groups (e.g., APA, 1993; Olkin, 1999; Perez et al., 1999; Ridley et al., 1994; Sue et al., 1992), including the following:
   a. Ability to assess such issues as clients' level of acculturation, acculturative stress, and stage of gay or lesbian identity development (e.g., APA, 1993; Dana, 1993; McCarn & Fassinger, 1996).
   b. Ability to ascertain effects of therapist–client language difference (including use of translators, if necessary) on psychological assessment and intervention (e.g., APA, 1993; Dana, 1993; Sue et al., 1992).
   c. Ability to establish rapport and convey empathy in culturally sensitive ways (e.g., taking into account culture-bound interpretations of verbal and nonverbal cues, personal space, and eye contact; e.g., Dana, 1993; McGoldrick et al., 1996; Olkin, 1999).
   d. Ability to initiate and explore issues of difference between the therapist and the client, when appropriate, and to incorporate these considerations into effective treatment planning (e.g., Olkin, 1999; Zayas, Torres, Malcolm, & DesRosiers, 1996).

as oppression, prejudice, discrimination, poverty, stereotyping, stigmatization, and marginalization (Competencies 3 and 4).

We realize that it would entail a life's work to become familiar with each of these dimensions for all 10 of the identified groups in the APA (1992) ethics code. Thernstrom (1980) identified more than 110 U.S. ethnic groups alone. Besides developing an appreciation for the general effects of such experiences as oppression and stigmatization, clinicians ought to know about such issues as family structures, worldviews, and help-seeking behaviors for the main groups they are likely to encounter professionally. As the reference citations in Table 1 indicate, this material is readily available in written form and is often covered in multicultural continuing education seminars.

Both awareness and knowledge competencies are essential prerequisites to developing adequate multicultural skills. These skills include being able (a) to conduct culturally sensitive interviews and assessments (Competencies 11 and 12); (b) to form accurate, nonbiased conceptualizations (Competency 9); and (c) to plan and implement nonbiased, effective treatment plans (Competency 12). Perhaps of greatest importance is the ability to accurately evaluate the adequacy of one's skills and to take corrective actions as needed (Competency 10).

Three Case Examples

To illustrate the 12 competencies, we describe Dr. Smith's three new hypothetical referrals. For each case, a brief clinical summary is followed by a discussion of selected competencies and how each competency could influence conceptualization and treatment; culturally informed hypotheses are offered to guide and enhance professional practice.

Sam Waterstone

Case description. Sam Waterstone is a 49-year-old, single, Native American male nurse who was referred to Dr. Mary Ann Smith for a psychological evaluation by the attorney representing him in a discrimination suit against the local school board. Mr. Waterstone is moderately guarded during the interview, providing coherent and logical responses to the examiner's questions, but without elaboration or spontaneity. His affect is rather restricted, and he focuses his eye contact intensely and unwaveringly on the examiner. He is a physically large man, appropriately dressed in a dark suit and an open-collared shirt imprinted with bears, lions, and wolves. Tattoos are visible at the neckline and at his wrist cuffs but are mostly covered by his clothing.

He explains that he was born and raised on a reservation. His father, a medicine man, was killed in an accident when Sam was a young teen, and his mother had arranged for him to attend high school in the city with the family of a relative. He worked his way through college by learning tribal medicine and hosting ceremonies and sweatshops, as his father had done. Sam aspired to learn "White man's medicine" so that he could explain it to his people. He had settled, instead, on a nursing degree and had been employed as such in the secondary school system for 25 years. He had never married and had no children. He reported no psychiatric or significant medical history.

When discussing the lawsuit, Sam reported that school officials had never told him the truth and had assigned him the most difficult schools, the worst facilities, and the oldest equipment. He reported that they had continuously harassed him about his traditional healing practices, his tattoos, and his need to be absent for an extra week at the beginning of the school year to attend a highly valued national tribal medicine gathering. He explained that, as a medicine man, he felt renewed and purified by his involvement in these tribal medicine ceremonies. His recent participation in one such gathering, however, had caused him to be fired because he missed the first week of school after a request for vacation was denied.

As Mr. Waterstone and Dr. Smith concluded the session by scheduling his return for more formal testing, he pulled from his pocket a small pouch of tobacco, extending it the examiner. He said, "It is traditional to give a gift to someone who you think will be able to help you."

Discussion of competencies. With adequate knowledge of the history of Native Americans in general and Sam's tribe specifically (Competency 3), the examiner could more accurately ascertain the extent of cultural paranoia expressed by Mr. Waterstone (fears about how one will be treated on the basis of a history of prejudice and discrimination) versus the alternate hypothesis of functional paranoia (Competency 9). Likewise, taking into account the cultural context, the examiner would not consider the category

of delusional disorder when Mr. Waterstone mentioned that he believes strongly in the spirit world (Competency 5).

Mr. Waterstone's status as a medicine man must be appreciated for the examiner to understand the importance that the annual gathering holds, so his actions are not interpreted as irresponsible or frivolous (Competency 9). Given his role as a healer, a collaborative approach to evaluation may be more successful than an authoritative one (Competency 9).

Also, the multiculturally competent examiner would probably attribute Mr. Waterstone's dilemma, in part, to the difficulty of balancing two cultures and his experience of acculturative stress when the two clash (Competency 12a). Likewise, the attitudes of school officials regarding naturalistic remedies, and even tattoos, might be best understood in the context of how these attitudes might further alienate Mr. Waterstone, for whom these practices have a much different meaning (Competency 4). In addition to these ethnic considerations, Sam also likely experiences prejudice in the school system as a man in a gender-atypical profession.

Mr. Waterstone's manner of presentation might be unsettling unless the examiner realized that he had to focus on her eyes rather than her words to determine if she could be trusted (Competencies 6 and 12c). Moreover, Mr. Waterstone's tattoos and the meaning of the animals on his shirt might be mentioned as an acknowledgment of their importance (Competency 12c). Finally, under most circumstances, it would be improper to accept a gift from a client, especially at intake. However, the examiner might make a concession in this case to honor the relational set intended by the gesture (Competency 12c).

Esperanza Mesa

Case description. Esperanza Mesa, a bilingual (Spanish–English) lesbian born in Durango, Mexico, is one of six children whose parents immigrated from Mexico when she was approximately 4 years old. Spanish was her first language, and she learned English in the public schools. Esperanza was an outgoing child who always doubted her self-worth. Feeling the sting of discrimination because of her dark coloring and accent when she spoke English, she changed her name to the English translation, Hope, while in high school.

When Hope was a teenager, she wondered if other teenage girls were drawn to women like she was. She succeeded in suppressing her feelings, and following her family and cultural dictates, she married and gave birth to a daughter by the age of 20. Hope never questioned her choices and felt compelled to follow the mandates of her family and Catholicism. Without these buffers, she would have felt even more desperate when people confronted her for being a "greasy, lazy, wetback Mexican who should just go home." As a married woman with a new baby, she felt lonely most of the time, and she knew it was not because she longed for her husband. There was a part of her that she shared with no one.

She felt like she did not fit anywhere, particularly with the other wives who gathered together in the afternoon before their husbands came home. She slowly began to realize that her motivation for visiting with this group was different from that of the others and that a strange attraction was growing within her toward one of the women. Unable to reconcile her cultural values and family loyalty with what she was thinking and feeling (including guilt and shame at wanting to put herself first), she told her husband about

her dilemma. Hope's traditional Mexican husband could not tolerate the option that Hope proposed—a divorce with her having full custody of their daughter. In fact, he threatened to expose her as a lesbian to her family and church and to take their daughter away. Because Hope feared her family's and priest's disapproval and rejection as well as the possible loss of her daughter, she sought psychotherapy for symptoms of anxiety, insomnia, loneliness, and rage.

Relevance of the competencies. To effectively treat Hope, the clinician must first closely examine her own feelings and values regarding lesbianism, the sanctity of marriage, and the permissibility of divorce (Competency 1). If, for example, the clinician inappropriately applies her own European American, more permissive values about marriage and divorce, she might easily minimize the nature and intensity of Hope's dilemma. Likewise, the culturally competent therapist needs to appreciate the strength of Mexican cultural norms toward role conformity as a woman, wife, and mother (Competency 8). Similarly, "airing one's dirty laundry" is not to be done in Hope's culture, especially to strangers such as the clinician (Competency 6). As a result, her request for psychotherapy may be contributing to her current distress.

Knowledge of lesbian identity issues and development is also essential to effective therapy (Competencies 8 and 12a). Evaluation of the extent of Hope's internalized homophobia, an understanding of the emotional upheaval common in the "coming-out" process, and an appreciation of the Mexican American proscription regarding disclosure of a lesbian identity (Greene, 1994) are essential to appreciate the courage it took for Hope to maintain her integrity in the face of such strong pressures and sanctions (Competency 9). Another painful decision that Hope is likely to face is whether to remain more identified with her Latina culture, in which there is little acceptance of lesbianism and in which she may have to remain more closeted, or to identify more with the dominant culture, which tends to be a bit more accepting of lesbianism (Competency 12a). The therapist's task is first to help Hope identify and articulate for herself the dual identity and its inherent dilemma and then to allow Hope to make the balances and integrations that work best for her (Competency 12). In addition, given her husband's response, Hope may be experiencing greater self-doubts and further self-questioning: For example, should she separate, share custody, and not try for a divorce? Should she remain single to prevent stigmatization of herself and her daughter, or should she allow herself to pursue a lesbian relationship? How should a potential lesbian partner be introduced into the family unit, if at all? How much should a future lesbian partner and the child's father participate as coparents? Answers to these and other questions will likely emerge slowly as Hope sorts out the conflicts inherent in her dual identity.

Without sufficient cultural competence, the treating clinician might resort to standard assessment instruments to better understand Hope's symptoms. Given their questionable validity in this case (Competency 11), a culturally competent clinician might, instead, ask Hope to keep a diary of her experiences and feelings (Competency 7). In addition, Hope may prefer that therapy be conducted in her first language (Competencies 12b and 12c). If Dr. Smith lacks Spanish fluency, she would need to refer Hope to an appropriate therapist (Competency 10). If Hope prefers English, Dr. Smith (anticipating that Hope may still prefer Spanish to express particularly strong emotions) might need to consult an

expert to help identify the appropriate Spanish terms as well as to master their pronunciation and correct usage (Competencies 10 and 12b). Using appropriate Spanish terms would help establish rapport and convey empathy, as would consideration of cultural preferences for *personalisimo* (preference for informality in relationships) and *platicondo* (chatting) in the therapeutic alliance (Competencies 6 and 12c). Furthermore, evaluation of the usefulness of involving a *currandero*, a Mexican spiritual healer, might be prudent, if not for Hope then for her estranged husband (Competency 6).

John McGowan

Case description. John McGowan, a 70-year-old visually impaired widower with a strong Irish heritage and culture, was brought to a clinician's office by his adult daughter after finding him disheveled, still in his pajamas, and crying over a bowl of uneaten cereal when she checked on him at noon. Between sobs, John could not convey to his daughter what had precipitated this latest incident.

When making the appointment, the daughter told the receptionist that her father had experienced other "weepy" episodes since Thanksgiving (3 months ago), but previously she had always been able to coax him out of them by playing some lighthearted Irish music. Since Thanksgiving, her father had had difficulty sleeping and seemed to have lost interest in most things that had previously given him pleasure. She added that her mother, who also strongly identified as Irish, had died suddenly of a heart attack 15 months ago. Her father had always depended on his wife to "be his eyes" and to care for his daily needs. They had met while still in parochial high school and became engaged shortly after graduation. When John was 19, he suffered severe visual impairment from a car accident, which prevented him from completing a plumber's apprenticeship. During their subsequent 48-year marriage, his wife supported them both, and neighbors cared for their daughter during work hours. John spent his days reading Braille versions of poetry and fiction, with unrealized aspirations of being a writer. Since his wife died, he had learned to use a cane but resisted the idea of having a Seeing Eye dog. As a result, he was mostly confined to his small apartment, leaving only to have a drink on Saturday night at the local bar, to attend Sunday mass, and to visit his daughter's family. He had very limited financial resources because he was no longer covered by his deceased wife's pension; however, the daughter was so concerned that she agreed to pay "out of pocket" for her father's treatment.

Relevance of the competencies. Imagine that Dr. Smith has knowledge and experience in working with visually impaired, indigent Irish Americans. With this background, she may have decided to meet initially with John alone—out of respect for the characteristically strong Irish sense of privacy. She would use the "sighted guide technique" for greeting him in the waiting area, asking simply, "Would you like to take my arm?" On entering her office, the clinician would inquire if John wanted a description of the space, being sure to note the possible seating options and the location of windows and lighting (because some visually impaired individuals are adversely affected by glare and illumination). She might begin the interview with factual questions regarding his current living situation, the extent of his visual impairment, and his recent medical and psychological symptoms, only later broaching

the more emotion-laden topic of the death of his wife. Likely, she would consider multiple hypotheses regarding the etiology of his depression, including his unresolved grief over the death of his wife, his lack of adequate independent coping skills in her absence, the contribution of his Irish heritage to his reluctance to ask for help and to his fatalistic outlook, the isolation and depression common in visually impaired individuals, the possibility of an organically based onset, plus the real-world economic constraints impinging on his life. The culturally competent psychologist would search for a delicate balance between the need to verbalize facial or bodily gestures to compensate for John's lack of visual acuity and his traditional Irish culture's prohibition regarding overt emotional expressiveness. In keeping with the cultural mandate to avoid direct expressions of difference or conflict, the psychologist would be likely to use humor and storytelling to indirectly explore differences between herself and John.

In summary, this case illustrates many of the multicultural competencies outlined in Table 1. Clearly any psychologist treating John needs to be aware of his or her own expectations and prejudices about visually impaired, elderly, Irish, Catholic, and poor individuals (Competency 1). All five of these identified groups with which John affiliates have experienced oppression, prejudice, and discrimination; to the extent that they are relevant, the cultural and personal impact of these societal judgments needs to be factored into John's treatment (Competencies 3 and 4). Likewise, societal perceptions of individuals with disabilities have changed over time (Kahn, 1984), and this historical context may also be relevant for both assessment and treatment (Competency 2). How much is John's social isolation a function of his avoidance of cruel remarks about his blindness versus his lack of independent coping skills? Knowledge of Irish values about illness, help-seeking behaviors, interactional styles, and worldview (Competency 6) is central to the careful consideration of both emic (culture-specific) and etic (universal) hypotheses (Competency 9). Perhaps John has an organically based depression and/or a dependent personality disorder (etic hypotheses). Information about Irish family structures and gender roles (Competency 8) is essential to fully consider the applicability of a dependent personality disorder diagnosis. Conversely, a myriad of culture-specific factors may influence John's situation (see McGoldrick et al., 1996, for a discussion of Irish heritage; see APA Working Group on the Older Adult, 1998, for a summary of clinical issues related to older adults; and see Harsh, 1993, and Olkin, 1999, for issues related to visual impairment). Use of appropriate assessment instruments for a visually impaired elderly client is essential to facilitate accurate diagnosis (e.g., the Geriatric Depression Scale; Competencies 7, 11, and 12b in Table 1). Likewise, psychologists with theoretical prohibitions regarding physical contact with clients will likely have to work through the necessity of touch to lead a visually impaired person to the consultation room (Competency 10). Although acculturation is often discussed in relation to African Americans, Native Americans, Asian Americans, and Latinos–Latinas, accurately ascertaining the role of John's Irish heritage is essential to a clear conceptualization of his issues (Competency 12a), the establishment of solid rapport (Competency 12c), and the selection of effective strategies to explore differences between the therapist and the client (Competency 12d).

Implications and Applications for Practitioners

The idiographic approach embedded in both our definition of multicultural competence and the 12 competencies places the emphasis on "understanding what is useful or meaningful to the client as a person, not simply as a representative of certain cultural groups" (Ridley et al., 1994, p. 242). As the aforementioned case examples illustrate, this stance creates useful, case-specific, culturally sensitive hypotheses to guide professional practice. It also can promote an understanding of within-group differences, rather than stereotyping clients on the basis of particular group membership.

The 12 competencies provide a core of awareness, knowledge, and skills applicable both across and within various identified groups. One of the primary implications of this list is that reliance on one's generic psychotherapy skills (empathic listening, astute questioning, and empowerment-oriented interventions) will not fully address the needs of most clients with whom we differ. Cultural competency requires specific, identifiable awareness, knowledge, and skills, and this list enumerates these in clear, outcome-oriented language.

These competencies are presented as a criterion by which practitioners can judge their compliance with the APA ethical mandate to provide competent services to clients from diverse groups (APA, 1992, Standard 1.08, p. 1601). Clinicians can ask themselves, Would I have treated Sam, Hope, and John appropriately? Which competencies are strengths and weaknesses for me? How broad-based versus specifically focused is my knowledge of particular groups? What can I do to build on my strengths and ameliorate my current weaknesses? When do I need to seek case consultation?

These competencies can also be used as a benchmark for knowing when to refer a client to a more competent practitioner. What if Dr. Smith had never worked with a lesbian client before? What if, after careful introspection, she realized she was quite homophobic? In such a situation, Dr. Smith should refer Hope and not attempt to "learn by doing."

On the basis of these three cases alone, a multiculturally competent clinician would need to know about three different ethnic groups (including a specific tribe); learn Spanish; appreciate what needs to be described to a visually impaired person about one's office; understand the group-specific use of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) and other assessment tools; and examine and transcend cultural conditioning regarding poverty, holistic medicine, lesbianism, religion, tattoos, and touch. Realistically, clinicians need to expand their multicultural competence by targeting certain groups with which to specialize. Practitioners need to ask themselves, What are the most common diversity issues for my client referrals? About which populations do I want to learn more? For which groups do my biases preclude competent treatment? If every practitioner expanded his or her multicultural competence by learning about two new groups, it would make an enormous difference in the delivery of quality mental health services in this country.

Practitioners (and educators) can also use this list to direct their multicultural professional development efforts. Each competency in Table 1 is accompanied by suggested references to guide self-study. Likewise, the list could be used to help select and integrate

what are often piecemeal, 1- or 2-day, continuing education workshops. Adequate professional retraining requires more than self-instruction, reading programs, and occasional conference workshops (Cheatham, 1994). Ongoing consultation groups could be established using either face-to-face or electronic formats to facilitate the kinds of personal introspection necessary to ensure adequate awareness-oriented competency. Clinicians might also want to follow Pope-Davis, Breaux, and Liu's (1997) recommendation for cultural immersion experiences (participatory, ongoing contact with a different culture) to enhance awareness of themselves and others.

Skill development is best learned in some sort of apprentice model, such as formal supervision or informal case consultation. The list could be used to screen potential supervisors, and consultants. How knowledgeable is a potential supervisor about the multicultural issues that you are likely to encounter? How much work has the consultant done on his or her own ethnic identity? In a similar vein, individuals serving as multicultural supervisors or consultants could use the list to self-assess their competency to manage this additional role. How much do I know about culture-specific diagnostic categories? How skilled am I at accurately evaluating emic and etic hypotheses? How able am I to modify traditional assessment techniques? Adequate evaluation of multicultural competency is related to the profession's ongoing struggle to define the general parameters of professional competence (Koocher & Keith-Spiegel, 1998). In addition to competency lists such as the one presented here, discussion of cases (in the literature and among colleagues) will help the profession refine its consensual definition of multicultural competence and the associated standards of care. Consultation with colleagues who have multicultural expertise is essential to evaluating the adequacy of one's training, experience, and supervision and to competently managing multicultural clients. Merely chatting with an available colleague down the hall between sessions is likely to be insufficient.

One evaluative criterion involves the ability to acknowledge openly one's professional limitations. When we lose sight of our shortcomings, we increase the possibility of damaging clients and the profession. Seeking frequent evaluative feedback from clients helps ensure clinical sensitivity. In addition, creating an environment in which acknowledging deficiencies is accepted and not shamed (e.g., graduate programs, continuing education workshops, peer consultation groups) would enable professionals to recognize both their multicultural limitations and their general clinical shortcomings. Such humble admissions of our limitations would also guide us to make appropriate referrals when necessary or catalyze us to obtain needed competencies.

In addition, formal credentialing and evaluative steps are essential. At least one state (i.e., Massachusetts) now requires a course in multiculturalism for professional psychology licensure. The field has thus far relied too heavily on self-report measures of multicultural competence (Ponterotto et al., 1994), even though recent research has reported no relationship between self-report scores and multicultural case conceptualization skills (Ladany et al., 1997). Measures such as the Cross-Cultural Counseling Inventory—Revised (LaFromboise, Coleman, & Hernandez, 1991), designed for use by supervisors in evaluating therapists' multicultural competencies, are an important first step in developing multimethod evaluation processes. Likewise, after a consensual definition of multicultural competency is established, these criteria

could be easily integrated into existing evaluation rating scales used for oral licensure and American Board of Professional Psychology exams, clinical quality assurance evaluative review criteria, and graduate school preinternship clinical evaluations (Radecki-Bush, Giannetti, Hansen, & Bush, 1998). Use of portfolio evaluations (Coleman, 1997) as well as recently developed coding systems to assess multicultural conceptualization skills (Ladany et al., 1997) may also help to ascertain the nuances of multicultural competence for professional psychologists. Furthermore, the courage to confront colleagues who may be practicing outside their areas of expertise is essential to enforcing all forms of appropriate professional behavior.

If the profession does not move proactively to ensure multicultural competence, the courts will. A recent Florida ruling requires mental health agencies to provide therapists who are fluent in American Sign Language to deaf clients, rather than depending on interpreters (Raifman & Vernon, 1996). Although this suit was brought under the Americans With Disabilities Act, others will most likely be filed as malpractice claims. Just as other landmark malpractice suits have reshaped clinical practice (e.g., the Tarasoff duty to protect case; cf. Koocher & Keith-Spiegel, 1998, pp. 121–123), it is only a matter of time before the courts intervene to enforce standards of multiculturally competent clinical care.

Implications and Applications for Training Programs

Although many professional psychology programs now offer at least one course on some aspects of multicultural issues (Allison et al., 1994; APA, 1996b; Bernal & Castro, 1994; Quintana & Bernal, 1995), the outcomes of these efforts over and above expanded awareness (Mintz et al., 1995; Neville et al., 1996) are mostly unclear and undocumented (Allison, Echemendia, Crawford, & Robinson, 1996). It is also not always clear how such course work fits within the APA accreditation-mandated "thoughtful and coherent plan to provide students with relevant knowledge and experiences" about multiculturalism (APA, 1996a, p. 10). The list of practice-oriented multicultural competencies described here represents a model of an idiographic, inclusive approach (Ridley et al., 1994). As such, these competencies could serve as a point of departure for other programs developing or refining the curricular portion of their "thoughtful and coherent plan."

These competencies are presented in such a way that they could help structure the content of a specific graduate course on multicultural issues or provide guidance for infusing the entire curriculum with diversity considerations. Although the latter is the recommended pedagogical approach (APA, 1996b; Ridley et al., 1994), the former is more common (Allison et al., 1994). Accordingly, a professor teaching social bases of behavior might consider adding units specifically on the history and manifestations of oppression, prejudice, and discrimination in the United States and their psychological sequelae (Competency 3) and sociopolitical influences (e.g., poverty, stereotyping, stigmatization, and marginalization) that impinge on the lives of identified groups (Competency 4).

Development of multicultural competencies is not a static task. It requires an open, flexible commitment to ongoing introspection, education, and involvement. Promoting such lifelong learning is a new accreditation guideline (APA, 1996a), and graduate school faculty would do well to instill in students a curiosity about

differences and a desire to learn more, along with conveying multicultural content.

To be effective, use of these proposed competencies needs to be coupled with systematic, long-range recruitment and retention efforts of faculty and students from historically underrepresented groups (APA, 1996a, 1996b). Programs also need to "ensure a supportive and encouraging learning environment appropriate for the training of diverse individuals" (APA, 1996a, p. 9). Each program will create a somewhat different culturally supportive milieu, but they all share a common need—faculty and students must take ownership of the holistic plan and process for the plan to be optimally effective.

Conclusion

These proposed multicultural competencies provide guidance for clinicians, educators, and students alike about how best to assess their existing multicultural competencies and how to direct their efforts to develop additional proficiencies. Although much has been written in the past 15 years about the importance of such processes, it is time to translate rhetoric into tangible action. We hope that these outcome-oriented multicultural competencies help individuals like Dr. Smith by moving the profession as a whole closer to this essential goal.

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