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A Model for the Theoretical Basis of Cultural Competency to Guide Psychotherapy

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Over the past four decades, the mental health field has struggled to define cultural competency and its efficacy in psychotherapy. Recent cultural competency and treatment adaptation studies have pointed to predominant evidence that cultural competency yields positive experiences and outcomes in treatment. What remains largely unknown, however, is *why* cultural competency works. Existing literature provides guidance about knowledge, skills, and awareness for therapists to attain, and types and areas of psychotherapy to adapt to achieve cultural competency, but few have given a theoretical understanding explaining why these efforts would yield clinical improvement. In this paper, we present a thorough review of several decades of cultural competency and psychotherapy literature for the purpose of answering the question of how and why cultural competency works. Our literature analysis yielded 3 theoretical principles that explain the mechanisms of cultural competency. Cultural competency works because it creates: (a) a contextual match with clients' external realities; (b) an experiential match in the microsystem of the therapeutic relationship or framework; and (c) an intrapersonal feeling of being understood and empowered within the client. These theoretical principles unify a broad and variegated cultural competency and psychotherapy literature, and provide a common foundation for understanding the basic principles and mechanisms of culturally competent psychotherapy. A case example is provided to demonstrate clinical practice implications. The proposed theoretical model is preliminary with future research needed to empirically test these principles as mediating variables in the process of cultural competency in psychotherapy.

Keywords: cultural competency, culture, diversity, theory, psychotherapy

There is a growing need for psychotherapies that are both empirically supported and culturally sensitive for cultural minority populations (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Hall, 2001). Given the increasing diversification of the United States in conjunction with well-documented disparities for cultural minorities in access to quality mental health services (U.S. DHHS, 2001), culturally competent practice guidelines and mandates have been established at local, state, and national levels (American Psychological Association [APA], 2003; Center for Mental Health Services, 2000; Sue, Zane, Nagayama Hall, & Berger, 2009). Indeed, recent studies point to predominant evidence that cultural competency (in the form of cultural adaptations) yields greater treatment efficacy (e.g., Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Smith, Rodriguez, & Bernal, 2011; van Loon, van Schaik, Dekker, & Beekman, 2013), though the evidence has been mixed (e.g., Huey & Polo, 2008).

Despite such progress, little is known about *why* cultural competency works. Research has been insufficient in identifying psychotherapy components of change based in theoretical explanations of the mechanisms of cultural competency (Sue et al., 2009). The purpose of this article is to examine how and why cultural competency works, and inductively derive theoretical principles and a model to explain the mechanisms of cultural competency in psychotherapy.

Definition and History of Cultural Competency

While there is general consensus surrounding the importance of attending to cultural and diversity issues in psychotherapy, definitions of cultural competence have been multifaceted with points of convergence and divergence (Whaley & Davis, 2007). At the core of all definitions is the idea that having skills and knowledge relevant to a client's cultural background is essential. A provider's

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cultural competence and sensitivity enhances the therapeutic process, contributing to positive therapeutic outcomes. However, differences exist regarding whether conceptualizations should emphasize (a) the kind of person the therapist is (person level); (b) the psychotherapeutic processes involved (process); or (c) the skills or intervention tactics the therapist uses (skills or intervention; Sue et al., 2009).

Cultural competency at the person level involves several therapist characteristics: (a) cultural awareness and beliefs, including sensitivity to the impact of one's values and biases on perceptions of the client, presenting problems, and the therapeutic relationship; (b) knowledge of the client's cultural background, worldview, and therapy expectations; and (c) cultural skills, encompassing the ability to provide culturally relevant and sensitive treatment (Sue, Arredondo, & McDavis, 1992). This person-oriented conceptualization of cultural competency, commonly known as the tripartite model, has been the most widely recognized framework (Sue et al., 2009) and has informed the foundation of the multicultural guidelines and competencies adopted by both the APA (2003) and the Society of Counseling Psychology (Division 17).

Process models of cultural competency emphasize complex interactions among the client, therapist, and treatment (López, 1997; Sue, 1998; Whaley & Davis, 2007). For example, Sue (1998) views cultural competence as a multidimensional process that includes three essential ingredients: (a) scientific mindedness by the therapist, which involves testing hypotheses rather than making premature conclusions about diverse clients; (b) dynamic sizing, which involves therapists' flexibility in knowing when to generalize versus individualize therapeutic approaches; and (c) culture-specific expertise in skills and knowledge of one's worldviews and the sociopolitical influences on clients' lives.

Finally, the skills or intervention cultural competency model encompasses skills or strategies to employ with diverse clients, similar to other specialized therapeutic skills that therapists learn and develop via training and supervision (Whaley & Davis, 2007). Cultural adaptations of evidence-based treatments (EBTs) represent an integral component of the intervention model of cultural competency. Cultural adaptations of EBTs are defined as systematic efforts to modify interventions to enhance their congruence with clients' culture, context, and language (Bernal et al., 2009). Cultural adaptation efforts were seen as a needed cultural competency solutions to problems of low utilization, poor retention, underinclusion of cultural minorities, and lack of effectiveness versus efficacy studies in traditional EBT research (Bernal & Scharró-del-Río, 2001; Cardemil, 2010; Hall, 2001; La Roche & Christopher, 2008).

Gaps and Challenges in the Cultural Competency Literature

While all three person, process, and intervention models of cultural competency have their merits, several challenges remain in their implementation. First, the field has long struggled with inconsistencies in the operational definition and measurement of cultural competency, making it difficult for research to examine its importance, validity, and efficacy (Sue et al., 2009). Second, guidelines and mandates for culturally competent psychotherapy practice have been rather aspirational in nature, as they lack explicit and detailed implementation strategies and are largely not based on empirical studies (Sue & Lam, 2002; Sue et al., 2009).

Third, little is known about the psychotherapeutic mechanisms of change of cultural competency, making them less amenable to empirical testing. Process and dismantling studies are two typical approaches to understanding specific mechanisms associated with clinical outcome (Doss, 2004; Hunsley & Rumstein-McKean, 1999). Unfortunately, such studies based on person and process models of cultural competency have been sparse, due to the lack of theoretical explanations needed to identify change mechanisms, and inherent challenges in their operationalization, measurement, and experimental manipulation.

Intervention characteristics are more suitable to experimental control in that they can be more easily culturally adapted and compared with nonadapted interventions or treatment-as-usual. The intervention model also inherently encompasses practice of the person and process models of cultural competency, as modifications to interventions often involve implementing different knowledge, skills, or awareness by therapists and clients. Thus, by looking at literature on adapted treatment components as well as data about moderators or mediators of treatment outcome for cultural adaptations, one can discern what aspects of an intervention's content and delivery make it more culturally competent. Unfortunately, to date, the cultural adaptation literature has lacked this type of mechanism research, and cultural adaptations are generally described in methods rather than results sections (Cardemil, 2010).

As a result, a comprehensive theoretical basis for understanding the underlying mechanisms of cultural competency does not yet exist, and little is known about *why* cultural competency works. A theoretical model explaining the mechanisms of cultural competency is needed to contextualize existing cultural competency research and provide tailored guidance for culturally competent approaches with diverse clientele. Theory can also create a unifying foundation for next steps of advancement in the field of cultural competency.

Purpose of This Article

In this article, we comprehensively review research regarding cultural competency in psychotherapy to inform a theoretical explanation of why cultural competency works. Our examination encompasses all relevant cultural competency research on therapist cultural empathy and humility, therapist cultural self-awareness, client perception of therapists' cultural empathy and awareness, client engagement, culturally competent provider behavior (including microaggressions), racial/ethnic match, and cultural adaptations of treatment. Through this thorough review, we provide both an exhaustive understanding of the state of the cultural competency literature in psychotherapy, and an understanding of the theoretical mechanisms that make cultural competency effective. This article is the first to establish core theoretical principles of cultural competency that can serve as the foundation for future clinical implementation efforts and psychotherapy process research.

Theoretical Principle #1: Cultural Competency Creates a Contextual Match With External Realities

Scholars have argued that a paradigm shift from a predominantly intrapsychic perspective to an ecological systems approach to psychotherapy can be prudent when working with cultural minorities (Bronfenbrenner, 1979; Greenleaf & Williams, 2009; Neville & Mobley, 2001). In the psychotherapy context, a client's exosystem (social and environmental factors and processes which indirectly impact one's immediate contexts) and macrosystem (overarching norms, values, beliefs, and traditions of society) encompass extratherapeutic factors that influence clients' presenting problems. For instance, research has consistently shown that cultural minorities are disproportionately impacted by macro- and exosystemic risk factors such as discrimination, poverty, immigration, homelessness, violence, inadequate educational and social resources, and community disorganization, all of which have detrimental effects on mental health and functioning (U.S. DHHS, 2001; Carter, 2007). Furthermore, while stigma attached to mental illness and treatment is a pervasive social phenomenon and public health issue, research suggests it is disproportionately pronounced among ethnic minorities (U.S. DHHS, 2001; Gary, 2005; Jimenez, Bartels, Cardenas, & Alegría, 2013). As such, attention to external macro- and exosystem factors may be particularly important in psychotherapy with cultural minority individuals. In this section, we review cultural competency research supporting the first theoretical principle that *cultural competency works because it creates a contextual match with clients' external realities*.

Contextualizing Psychotherapy Through Treatment Content, Structure, and Delivery

Within cultural adaptation research, three treatment components are often modified to create a contextual match with clients' external realities: treatment content, structure, and delivery. First, *treatment content* adaptations modify the cultural relevancy of an intervention's curriculum and materials to clients' cultural context/life circumstances, and incorporate culturally relevant metaphors, stories, and values to convey key therapeutic principles (Cardemil, 2010). For example, in adapting cognitive–behavioral therapy for low-income African American adolescents with anxiety, Ginsburg and Drake (2002) addressed neighborhood crime and violence and issues related to stepparents and siblings, drug use, and financial hardship. LaFromboise and Rowe (1983) added a bicultural competence component to an assertive skills training program for American Indians who were struggling to effectively navigate two cultural worlds. Moreover, several studies have integrated the cultural value of *familism* when working with Latinos, acknowledging the important cultural role of family (e.g., Aguilera, Garza, & Muñoz, 2010; Domenech Rodríguez, Baumann, & Schwartz, 2011).

Second, *structural adaptations* add adjunctive components that make treatment more culturally sensitive to clients' daily lives and struggles (Cardemil, 2010). For example, in congruence with the collectivistic orientation of Latino families, Kopelowicz, Zarate, Gonzalez Smith, Mintz, and Liberman (2003) involved clients' relatives in the treatment skills training and reinforcement process for Latinos with schizophrenia. Other culturally adapted treatments commonly incorporate case management to address psychosocial stressors (e.g., poverty, lack of resources and access to services) commonly faced by cultural minorities that can negatively impact mental health and treatment progress and retention (e.g., Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Satterfield, 1998).

Finally, *treatment delivery* adaptations may accommodate external environmental demands by remaining flexible in scheduling sessions, offering childcare on site so parents can engage in treatment, or providing transportation vouchers (e.g., Cardemil et al., 2005; D'Angelo et al., 2009; Patterson et al., 2005). Other studies have emphasized the importance of offering treatment in settings more accessible and/or congruent with cultural minorities' service utilization patterns (i.e., primary care clinics, local community centers, etc.; e.g., Chavez-Korell et al., 2012; Domenech Rodríguez et al., 2011; Kopelowicz et al., 2003).

Taken together, empirical studies on cultural adaptation of psychotherapy demonstrate the need for modified treatment content, delivery, and structure to enhance the external validity and acceptability of an intervention for cultural minorities. Such research supports the notion that cultural competency works by creating a contextual match with clients' external realities.

Theoretical Principle #2: Cultural Competency Creates an Experiential Match in the Microsystem of the Therapeutic Relationship or Framework

Bronfenbrenner's (1979) ecological theories have long recognized the influence of multiple levels of environmental context on any individual person. Just as congruence of psychotherapy with the external realities of one's macro- and exosystems influence cultural competence, a review of treatment- and provider-level cultural competency literature indicates that experiential match at the microsystem level (entities with the most direct interaction and impact) is also important. In the psychotherapy context, the most salient microsystem is that of the provider and client interaction (i.e., the therapeutic dyad or therapeutic framework). The following section details the research support for the second theoretical principle that *cultural competency works because it creates an experiential match in the microsystem of the therapeutic relationship or framework/environment.*

Cultural Match With the Therapeutic Relationship

Two main subsets of the cultural competency literature indicate that an experiential match within the therapist–client relationship explains why cultural competency works in psychotherapy: ethnic match and provider behavior research.

Racial/ethnic matching between therapist and client. Over three decades of research have examined the questions of whether ethnic minority clients prefer ethnic match with their therapists, and whether ethnic match yields greater treatment retention and outcome. Research shows that ethnic minority clients have a moderate to strong preference for an ethnically matched therapist, especially when there is identification with their cultural group (Cabral & Smith, 2011; Coleman, Wampold, & Casali, 1995). Substantial evidence suggests that ethnic and language match between therapist and client is associated with longer therapy attendance and lower treatment dropout among multiple ethnic minority groups, although results have been mixed with small effect sizes, limitations in study sampling and methodologies, and

difficulties in isolating the effects of ethnic versus language match (Ibaraki & Nagayama Hall, 2014; Karlsson, 2005; Maramba & Nagayama Hall, 2002; Shin et al., 2005). These effects of racial/ethnic match vary depending on client race/ethnicity, age, gender, or education (Cabral & Smith, 2011). In response to the perceived benefits of matching on treatment retention, many mental health organizations have adopted ethnic and language match in their service delivery practices (e.g., Mathews, Glidden, Murray, Forster, & Hargreaves, 2002).

In contrast to the research on therapy retention, even less evidence supports a relationship between ethnic and language match and improvements in clinical outcomes (e.g., Cabral & Smith, 2011; Karlsson, 2005; Maramba & Nagayama Hall, 2002; Presnell, Harris, & Scogin, 2012). However, recent meta-analyses of cultural adaptation studies have found that interventions conducted in clients' non-English native language are twice as effective as those conducted in English, and that interventions with groups of same-race participants are four times more effective than mixed race participants (Griner & Smith, 2006; Smith et al., 2011).

A core assumption of the focus on ethnic/language match is that pairing linguistically or ethnically similar therapists and clients is an essential component of culturally competent services. Essentially, many treat ethnic and language match as proxies for cultural competency. As such, an examination of the reasons why ethnic and language match may be preferred by some clients and yields greater therapy retention can shed light on the question of why culturally competency works.

Literature explaining the mechanisms of ethnic match indicates the importance of a number of culturally relevant factors between provider and client. For example, theoretical and empirical works have indicated that ethnic match works because ethnic minority clients perceive ethnically matched therapists as more credible, trustworthy, and less biased toward and more competent with their ethnic group (Cabral & Smith, 2011; Karlsson, 2005). In addition, researchers have suggested that ethnic minority clients may have similar background experiences, nonverbal and verbal communication, and may have stronger therapeutic alliance with a stronger inclination to disclose, with an ethnically similar therapist (Cabral & Smith, 2011; Karlsson, 2005; Chao, Steffen, & Heiby, 2012), though results are mixed with a recent study finding no relationship between ethnic match and self-disclosure in an experimental setting (Zane & Ku, 2014).

Other researchers have pointed beyond ethnic match to the need for providers to be matched with clients on cultural worldviews and cognitive styles such as problem perception, coping orientation, and therapy goals (Zane et al., 2005). Cultural match in beliefs may influence the type of content covered in session, which in turn moderates treatment utilization (Ibaraki & Nagayama Hall, 2014). In fact, studies show that when participants are forced to rank preferences within paired comparisons, similarity in attitudes, beliefs, values, or personality are ranked higher than ethnic match itself (e.g., Atkinson & Lowe, 1995; Bennett & BigFoot-Sipes, 1991). Such research indicates that ethnic matching alone does not ensure cultural competency on behalf of the therapist, particularly given within-group diversity related to other cultural experiences and identities. With other factors (e.g., empathy, compassion, expertise, and shared worldview) impacting ethnic minority clients' therapy satisfaction independent of client/therapist ethnic match, clinicians of all ethnic backgrounds and within interracial therapist/client dyads (e.g., Caucasian therapist and African American client) can develop effective, culturally competent therapeutic relationships (Hays, 2008; Knipscheer & Kleber, 2004).

Overall, the literature suggests that cultural competency via racial/ethnic match may be important predominantly as a vehicle to greater cognitive and worldview similarity and positive perceptions of the therapist. Collectively, these studies support the theoretical principle that cultural competency works because of an experiential match (e.g., on multiple levels of communication, cognition, personality, trust, worldview, etc.) within the therapeutic relationship.

Provider behavior research. The provider-based cultural competency literature also shows it is important for therapists to account for cultural factors in the therapeutic relationship. Qureshi and Collazos (2011), for example, discuss how different cultural perspectives on worldviews, communication styles, ways of expressing emotions and other idioms of distress, and explanatory models (how illness is understood) between the therapist and client can negatively affect therapeutic communication and alliance. The authors propose that therapists skilled at matching their behaviors and approaches to the culturally informed experiences of their clients can overcome these cultural differences to build a strong therapeutic relationship and maximize treatment effectiveness. Indeed, multicultural experts consider the therapeutic relationship to be a strong predictor and integral component of effective culturally competent psychotherapy (e.g., Martin, Garske, & Davis, 2000; Paris, Anez, Bedregal, Andres-Hyman, & Davidson, 2005). In a meta-analytic study, Benish, Quintana, and Wampold (2011) found empirical support for these ideas, showing that culturally adapted psychotherapy is more effective with congruence between a client's cultural explanation of illness and the explanatory models underlying the provider's treatment approach.

Culturally competent therapists must also account for cultural factors related to racial bias or differences in majority-minority experiences between the therapist and client. Chang and Berk (2009) found that ethnic minority clients who reported dissatisfaction with their Caucasian therapists perceived that their therapists misunderstood and downplayed issues of power, privilege, and discrimination more frequently than their satisfied counterparts. Recent microaggression research also suggests that when therapists display behaviors perceived by ethnic minority clients as insensitive to racial dynamics (e.g., with microaggressions, discrimination, or oppression), therapeutic alliance and perhaps clinical outcomes may be negatively affected (e.g., Owen et al., 2011).

Overall, the research on provider behavior and ethnic match research shows that by focusing on cultural factors that influence congruence within the microsystem of the therapeutic relationship, therapists can create a situation conducive to effective cultural competency.

Cultural Match With the Therapeutic Framework/Environment

Not only is congruence in the therapeutic *relationship* between provider and client key to cultural competency, but the cultural treatment adaptation literature suggests that therapeutic *framework* or *environment* is also instrumental. Within adaptation research, two particular components related to the microsystem of psychotherapy environment are often modified to fit the cultural needs of

cultural minority groups: treatment delivery and treatment structure.

Treatment delivery adaptations refer to changes in the way that core treatment components are delivered through variations in mode of communication, provider/client relationship style, or adjunctive delivery approaches. Numerous adaptation studies, for example, emphasize the important of delivering EBTs within a more informal or friendly therapeutic environment with Latino ethnic minority groups who value the cultural concepts of *personalismo* or *simpatia* (Chavez-Korell et al., 2012; Matos, Torres, Santiago, Jurado, & Rodriguez, 2006). Contrary to the more professional or rigid modes of treatment delivery typical of Western-based therapies, Latinos may expect the therapist to become part of their extended community networks (Comas-Diaz, 2006). In contrast, other studies have indicated a need for more advice-giving or directive treatment delivery with individuals expecting a hierarchical provider/client relationship (e.g., Chu, Huynh, & Arean, 2012; Ponce & Atkinson, 1989; Satterfield, 1998). Treatments may also be more culturally competent when delivered through incorporation of adjunctive methods, such as text messaging reminders to facilitate homework completion among Latinos with high rates of cell phone ownership (Aguilera, Garza, & Munoz, 2010).

Treatment structure adaptations—alterations to the organization of a treatment—also involve changes that improve the cultural fit of the therapeutic environment or microsystem. Structural modifications may include changes to the number and frequency of sessions (to increase focus on certain cultural content), group versus individual modality of sessions (to match a cultural emphasis on community network systems), or the integration of assessments and assignments (Cardemil, 2010; LaFromboise & Rowe, 1983; Matos et al., 2006). Hinton, Rivera, Hofmann, Barlow, and Otto (2012) added session time in their modified CBT for traumatized refugees to assess and treat culturally conscribed symptoms such as *ataque de nervios*. It is particularly common to add time during beginning phases of treatment to increase engagement (e.g., via targeted pre-therapy orientation or psychoeducation) among cultural minorities endorsing more mental health-related stigma or less familiarity with mental health services (e.g., Hwang, 2009).

Together, these adaptation studies illustrate instances where environment and treatment context (via treatment delivery and structure) need modification to increase acceptability and cultural fit of a treatment for cultural minorities. Such research supports the idea that match within the therapeutic framework or environment may explain why cultural competency works.

Theoretical Principle #3: Cultural Competency Creates an Intrapersonal Feeling of Being Understood and Empowered

Many aspects of the previous sections emphasize that specific *skills* and *behaviors* enacted by the therapist enhance the cultural congruence of psychotherapy with the external realities of clients' macro- and exosystems, and within the microsystem of the therapeutic relationship. These factors contribute to a therapeutic context culturally attuned to clients' personal worldviews, values, and experiences. In turn, these culturally competent skills and behaviors likely foster clients' feelings of being understood and empowered by their therapists.

More recently, researchers have suggested shifting focus to therapists' multicultural orientation (Owen, Tao, Leach, & Rodolfa, 2011), which is conceptualized as "a way of being" with diverse clients (i.e., an interpersonal stance or disposition) versus "a way of doing" therapy with diverse clients (i.e., how cultural competencies in the form of awareness, knowledge, and skills are implemented). This literature points to the concept of cultural humility, which entails a lifelong process of ongoing self-reflection, self-awareness, and self-critique whereby the therapist maintains an interpersonal stance that is other-oriented (i.e., openness to the other) in order to overcome the natural tendency to view one's own beliefs, values, and worldview as superior (Hook, Davis, Owen, Worthington, & Utsey, 2013; Tervalon & Murray-Garcia, 1998). A similar vein of research focuses on the *process* of a therapist developing *cultural empathy* via *self-awareness* (e.g., of biases, power and privilege) and understanding clients from different cultural backgrounds (Roysircar, 2004; Vázquez & García-Vázquez, 2003). The idea is that when therapists practice greater multicultural awareness and empathy, clients not only have more positive experiences with therapy, but they feel more understood and empowered, which in turn facilitates more successful treatment. This final section details research on therapist self-awareness, cultural empathy, cultural humility, client experiences of the cross-cultural therapy process, and empowerment supporting the final theoretical principle: Cultural competency works because it creates, in the client, an intrapersonal feeling of being understood and empowered.

Therapist Empathy and Self-Awareness in Cross-Cultural Psychotherapy

Empathy. Psychotherapy outcome research has consistently revealed that client-perceived therapeutic relationship factors—particularly therapist empathic understanding and acceptance—are not only positively related to clinical improvement, but generally show stronger associations than specific therapeutic techniques (Norcross, 2002). While empathy is a crucial facilitative condition in psychotherapy (Bohart, Elliott, Greenberg, & Watson, 2002), it may be particularly important with cultural minorities whose potential wariness of providers stems from present and historical struggles with discrimination, stereotyping, and provider bias that can result in misdiagnosis, inappropriate referrals, and substandard care (Boysen, 2009; U.S. DHHS, 2001).

In fact, traditional understandings of empathy may need expansion to account for cultural gaps between clients and therapists (Chung & Bemak, 2002). The term *cultural empathy* refers to a process by which a therapist accurately understands the experiences of a client from a different cultural background, effectively communicates this understanding, and simultaneously maintains awareness of his or her own cultural sense of self (including biases, attitudes, values, sources of power and privilege, etc.) and its impact on the therapeutic context (Chung & Bemak, 2002). Empathy has been shown to make unique contributions to multicultural competence, arguing for cultural empathy's role as one proxy for the construct of cultural competence itself. Indeed, some research indicates that affective empathy around issues of race and culture can be effective as an approach to cultural competence, as affective empathy is related to more positive attitudes toward

minorities and higher cultural sensitivity (Spanierman & Heppner, 2004).

Cultural competence via self-awareness. A distinguishing feature of cultural empathy is its emphasis on cultural *self-awareness*. In order to respond with cultural empathy, therapists must recognize that each person is a unique cultural being and understand how their own cultural subjectivity can influence their perceptions of clients, clinical judgment, decision-making, and the therapeutic relationship. In essence, when therapists critically examine their cultural subjectivity, they can better understand and empathize with clients' thoughts, feelings, and struggles (Chung & Bernak, 2002).

Indeed, self-awareness of one's worldview, cultural values, and racial identity has been considered a prerequisite for overcoming detrimental effects of *ethnocentrism* (evaluating other cultures according to one's own cultural preconceptions) and *cultural encapsulation* (assuming difference represents deficit or pathology) so that therapists can form positive multicultural counseling relationships, achieve accurate cultural empathy, and practice cultural competency (Chung & Bemak, 2002; Richardson & Molinaro, 1996; Sue et al., 1992). Self-awareness may serve as a proxy for cultural competence; integrated racial identity by counselors has been related to prior multicultural training, self-rated cultural competence, and less color-blind attitudes (e.g., Evans & Foster, 2000; Middleton et al., 2005).

Self-awareness of color-blind attitudes (i.e., greater denial, minimization, and distortion of the existence of structural racism) and its associated empathy for clients' marginalization experiences, is also a well-researched proxy for cultural competency. Neville, Spanierman, and Doan (2006) found that higher color-blind ideology by therapists was associated with lower multicultural knowledge, awareness, and case conceptualization abilities. Spanierman, Poteat, Wang, and Oh (2008) additionally found that trainees with lower color-blind attitudes experienced higher empathy and guilt (compassionate costs), which in turn predicted higher multicultural knowledge. Another qualitative study showed that differentials in power and privilege between therapist and client (an indication of incongruent awareness of cultural issues) impact counselors' reactions and their abilities to relate to clients (Hays, Dean, & Chang, 2007).

Supporting this idea of culturally competent self-awareness yielding greater empathy, several studies have found that therapists with lower awareness of racial issues or higher color-blindness are likely to misattribute minority clients' distress to dispositional rather than external reality factors like racism, discrimination, or social disadvantage (Burkard & Knox, 2004; Toporek & Pope-Davis, 2005). This misalignment of attributions may lead clients to feel wrongfully blamed, invalidated, and misunderstood. Burkard and Knox (2004) concluded that minimal awareness of racial issues impedes therapists' ability to empathize with clients, which may lead to diminished sensitivity to cultural issues in case conceptualization and treatment. Indeed, Neville, Awad, Brooks, Flores, and Bluemel (2013) found that color blindness may actually reflect racism.

Overall, cultural competency research on cultural empathy and self-awareness suggests that when therapists have less color-blind and biased racial attitudes, they are more empathic, nonjudgmental, and understanding toward minority clients and their minority stress experiences. In turn, therapist self-awareness and cultural empathy can elicit positive therapeutic experiences from cultural minority clients and create interactions where clients experience an intrapersonal feeling of being understood by and connected with their therapists.

Client Factors: Perceptions and Experiences of the Therapist and Therapy Process

Research investigating clients' perspectives also indicates that clients have positive experiences with culturally competent therapists because they feel understood. For example, therapists who are considered more culturally responsive have clients who feel more comfortable with intimate disclosure (Thompson, Worthington, & Atkinson, 1994), have higher client retention rates and ratings of satisfaction, expertness, trustworthiness, attractiveness, unconditional regard, and empathy (Wade & Bernstein, 1991), and are viewed as more culturally competent and credible (Atkinson, Casas, & Abreu, 1992).

Similarly, Chang and Berk (2009) found that clients dissatisfied with experiences in cross-racial therapy reported having therapists who had superficial or stereotypical cultural knowledge, minimized clients' experiences of oppression, and lacked awareness of the impact of their stereotypes/biases on the client. In contrast, satisfied clients reported having therapists who were culturally responsive and able to work through conflicts that arose from cultural differences. Fuertes et al. (2006) also examined cross-racial therapy dyads and found that clients' perception of therapist empathy, trust, and a strong therapeutic bond increased with perception of therapists' multicultural competence. In a qualitative study, Jim and Pistrang (2007) showed that Chinese clients identified helpful therapist qualities as being nonjudgmental, someone who can be trusted, and a good listener able to understand the client's internal world (i.e., empathic understanding). Conversely, disappointments with therapists coincided with perceptions of cultural encapsulation and lack of cultural knowledge and empathy. Further, research has shown that client perceptions of therapist cultural humility (i.e., an interpersonal stance that is characterized by respect and lack of superiority toward an individual's cultural background/experience) were positively associated with developing a strong working alliance, and that a strong working alliance mediated the relationship between perceptions of therapist cultural humility and client improvement in therapy (Hook et al., 2013).

Empowerment

Cultural competency may also work by engendering empowerment within cultural minority clients, many of whom have experienced overt or covert oppression and discrimination. The empowerment model is a "social change, advocacy, and therapeutic intervention that focuses on promoting assets and fostering strengths" (Querimit & Conner, 2003, p. 1216). Empowering cultural minority clients to understand the psychological and physical ramifications of societal prejudice and inequity can enhance the development of positive coping skills (Davis, Ancis, & Ashby, 2014; Querimit & Conner, 2003). Therapists can facilitate minority clients' awareness, empowerment, and/or activism around discriminatory societal experiences. By dismantling negative attitudes, clients can bolster their self-esteem, cultural awareness, self-efficacy, cognitive flexibility, assertiveness, and resource uti-

lization. For women of color, in particular, promoting empowerment via psychotherapy simultaneously honors their racial, ethnic, gender, sexual, and class experiences (Querimit & Conner, 2003).

Empowerment has strong empirical support in facilitating therapeutic alliance. Promoting empowerment can reduce African American clients' negative perceptions of therapists and enhance therapists' responsiveness to cultural factors for their clients (Davis et al., 2014). For Asian American clients, empowerment can reveal cultural disadvantages and challenges speciously concealed by perceptions of the "model minority" stereotype (Kim, 2014). Improved ethnic awareness through empowerment can lead to more accurate assessments of societal discrimination, potentially resulting in increased opportunities to cope with minority stressors and strengthen mental health (Kim, 2014). Therapists must also remain attuned to the interaction between client and therapist cultural identities, as awareness of power and privilege is at the forefront of empowerment-based work (Querimit & Conner, 2003).

Taken together, the aforementioned research on client and therapist factors reveal important insights into how cultural competency exerts its effects at the level of the individual client. Specifically, research supports that therapist cultural self-awareness is closely related to attitudes toward and awareness of the impact of race, culture, power, privilege, and oppression in clients' everyday lives. Through therapist attunement and facilitation of empowerment, minority clients can experience improved coping skills, cultural awareness, and mental health-related benefits. It is important for therapists to increase self-awareness about the cultural lens of their client interactions, as this is an important factor to achieving cultural empathy and ultimately creating a therapeutic context in which a client feels genuinely understood and empowered.

Application

The following de-identified case example of "Lucy" provides an illustration of the theoretical concepts discussed in this article. A pseudonym was used and some circumstances changed to protect confidentiality.

> Lucy, a 35-year-old Mexican American woman who lives with her husband and their 3-year-old daughter, immigrated to the U.S. at age 15 with her mother and two younger sisters and identifies as a devout Catholic. She has been married 4 years and states her husband (age 42) emigrated from Mexico 7 years ago. Lucy presented to an outpatient community mental health clinic complaining of immense sadness, anxiety, chronic fatigue, headaches, sleep disturbances, and feeling as though she is a "failure as a mother and a wife." Lucy reported never receiving a psychiatric diagnosis and began experiencing symptoms 3 months ago. She was given a diagnosis of major depressive disorder, single episode, with anxious distress.
>
> At intake, Lucy was unemployed with limited social support. Two years ago, she left her elderly mother, sisters, church friends, and a restaurant hostess job to move to a new city for her husband's new job. Since symptom onset 3 months ago, she has not attended church and has had limited phone contact with family and friends, not wanting to "burden" them with her problems. Lucy reported only moving with her husband for their daughter, whose conception was unexpected. She viewed her daughter as a "godsend" and loved her dearly, though she felt tremendous guilt when she wished she was never born. Lucy reported conflicted emotions about wanting to leave her husband (whom she described as emotionally neglectful, but their sole income source) to move back with her family. She had never been to psychotherapy before and stated she did not want her husband or family to find out. Lucy presented to the first session 20 min late with her daughter, profusely apologetic, stating she was unable to find a babysitter and missed her bus. She presented as warm and friendly, though she fidgeted nervously. Lucy stated she was "doing fine" but became tearful when discussing her marriage and family.

Treatment and the Mechanisms of Cultural Competency in Lucy's Psychotherapy

Psychotherapy with Lucy primarily involved a cognitive–behavioral therapy (CBT) approach to address thoughts of being a "failure" and ambivalence surrounding leaving her husband and being a mother that were contributing to her depression. Several cultural modifications to traditional CBT were germane to the success of Lucy's treatment.

First, cultural competency efforts were targeted at creating a contextual match with Lucy's external realities (theoretical principle #1). In treatment selection, the therapist considered the external demands placed on Lucy (e.g., limited resources, mother of a young child), and a short-term, problem-solving, present-focused CBT was chosen as a cultural fit. The therapist was also attuned to Lucy's secrecy and apprehension surrounding therapy likely suggestive of unfamiliarity and stigma associated with mental health issues. Therefore, a pre-therapy orientation and alliance-building phase was extended over three sessions to increase Lucy's comfort and engagement. The therapist also remained flexible in scheduling sessions by offering midday appointments that factored in the bus and Lucy's husband's work schedule. Lucy's daughter was allowed to attend sessions on days a babysitter was unavailable.

Treatment delivery also considered financial and transportation barriers and Lucy's cultural values surrounding family and religion. Activity scheduling involved Lucy going to church twice per week, maintaining regular phone contact with family and friends, and attending low-cost or free outings. When explaining CBT, church attendance and prayer were described as behavioral and cognitive activities that could help Lucy cope and enhance social support. In order to enhance the cultural relevance and external validity of treatment, the therapist also explored other pertinent issues impacting Lucy's life and mental health (e.g., experiences of racism, discrimination, disenfranchisement, and acculturative stress). For example, the therapist explored Lucy's stage of acculturation to contextualize her strained relationship with her husband, whom Lucy described as "traditionally machismo" and less acculturated.

Second, important to treatment success was ensuring that the microsystem of the therapeutic relationship and framework matched her culturally specific needs and expectations (theoretical principle #2). At the outset, Lucy's preference for ethnic and language match was assessed, and she was matched accordingly with a therapist who was English-speaking and a woman, regardless of ethnicity. Developing the therapeutic relationship was paramount, particularly given Lucy's initial treatment apprehension. In addition to extending the alliance-building phase of treatment, the therapist fostered a more informal and friendly therapeutic environment based on Lucy's interpersonal style and the cultural concepts of *personalismo* and *simpatia* (e.g., by self-disclosing

parent status as a mother and allotting session time for *desahogo*, or getting things off one's chest). Considering cultural values of respect and fears of burdensomeness toward others, the therapist framed therapy as a safe place for Lucy to voice her concerns if her needs were not being met. The therapist also considered Lucy's understanding and explanation of her symptoms (i.e., her pain was God's "punishment" for her failures as mother and wife). In addition to techniques to address Lucy's somatic concerns (e.g., relaxation, sleep hygiene), culturally sensitive cognitive restructuring involved accounting for Lucy's cultural values surrounding the centrality of family and religion in her life (including her beliefs about divorce).

Third, cultural competency was incorporated by facilitating Lucy's feeling of being understood and empowered (theoretical principle #3). While the therapist had certain identities in common with Lucy that helped facilitate the therapeutic alliance (e.g., being a mother and of similar age), she also remained mindful of her own cultural subjectivity and salient power/privilege differentials within the therapeutic dyad (i.e., with respect to race/ethnicity, nation of origin, socioeconomic status, and religion). This self-awareness facilitated the therapist's ability to effectively convey empathy and understanding about Lucy's cultural values and experiences. Lastly, the therapist fostered empowerment within Lucy by promoting her internal and external strengths/assets (e.g., her strong commitment to her faith and family, the support she received from her spiritual community), taking an empowering interpersonal stance (e.g., Lucy as the expert in her life), and openly discussing the psychological and physical impact of societal stigmata and inequities (e.g., acculturative stress, experiences of discrimination or disenfranchisement) in order to facilitate Lucy's ability to cope with these minority stressors. The therapist also redressed power and privilege imbalances within the therapeutic relationship by encouraging Lucy to speak openly about her experience working with a therapist from a different cultural background, all while maintaining a nonjudgmental and validating stance.

Implications of the Proposed Model

The current article presented a thorough review of several decades of cultural competency and psychotherapy literature for the purposes of answering the question of how and why cultural competency works for minority clients. Our literature analysis yielded three theoretical principles that explain the mechanisms of cultural competency as depicted in Figure 1. Cultural competency works because it creates: (a) a contextual match with clients' external realities, (b) an experiential match in the microsystem of the therapeutic relationship or framework, and (c) an intrapersonal feeling of being understood and empowered within the client. Depending on client and therapist factors, these three principles can be used individually or can be combined to further bolster therapeutic outcomes. The proposed model is preliminary and requires further research to empirically test its principles.

The first two principles emphasize congruence and fit between psychotherapy and clients' cultural systems (Leong & Kalibatseva, 2011; Sue, 1998). Three particular areas of cultural treatment adaptation research support the first theoretical principle (external reality match). Cultural adaptation studies indicated that EBTs are modified by integrating cultural content and examples (e.g., attention to acculturative stress issues for ethnic minority immigrants), adding structural treatment components (e.g., case management to assist with social legal challenges that refugees experience), and changing the way treatment is delivered (e.g., delivering treatment in community centers, offering adjunctive childcare on site) to reflect the external realities and demands of one's cultural context.

The second theoretical principle (experiential match of the microsystem) was induced from several historical lines of cultural competency research. Research on culturally competent provider behavior and racial/ethnic match suggests that therapists should match their behaviors and approaches to the culturally informed experiences (e.g., communication, cognition, personality, worldview) of their clients, and that providers should take care to attend to minority stress and racial issues without microaggression or discrimination. Cultural treatment adaptation literature indicates that therapeutic environment—the way that treatment is delivered and structured—should match clients' cultural expectations and needs.

Finally, research on therapist cultural empathy, cultural humility, cultural self-awareness (of identity, bias, power, and privilege), and client perception of therapists' cultural empathy and understanding support the third theoretical principle (intrapersonal feel-

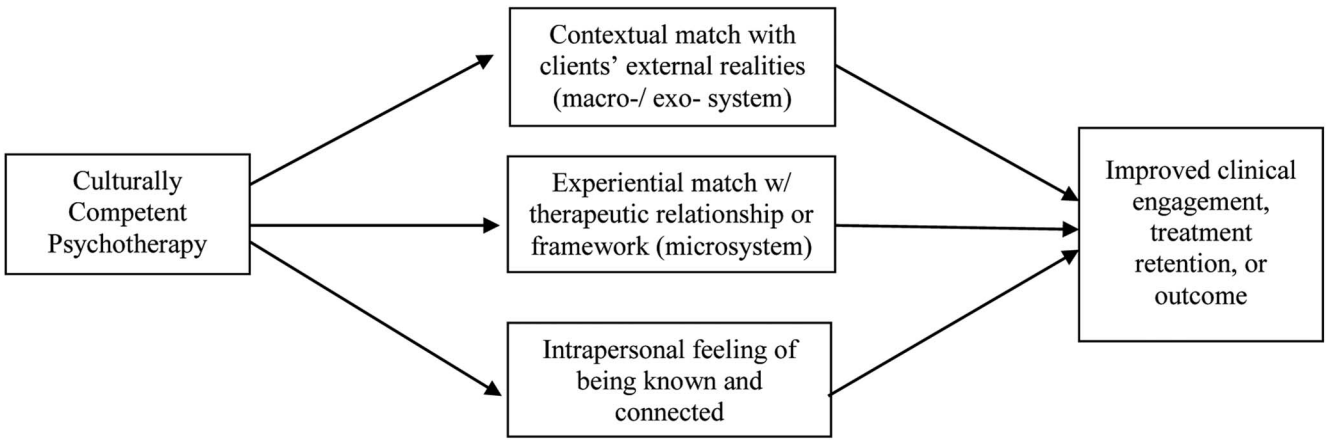

Figure 1. Three theoretical mechanisms of cultural competency.

ing of being understood and empowered). In particular, therapists who are self-aware of their own cultural identities, biases, power, and privilege, understand their own cultural subjectivity, communicate cultural empathy, and facilitate empowerment can create interactions in which clients experience an intrapersonal feeling of being understood and empowered, thus facilitating cultural competency and effective treatment and engagement.

This model is timely in light of recent increasing emphasis on psychotherapy integration and common factors (e.g., client and therapist variables, including empathy and the therapeutic relationship) in both research and practice, which in part relates to heightened awareness of limitations of "pure form" therapies, particularly among diverse populations (Cardemil, 2010; Krueger & Glass, 2013; Norcross, 2002 & 2005). Indeed, the culturally competent therapist is inherently "integrative" in their efforts to adapt and incorporate therapeutic approaches to address multiple facets of each client's unique psychological and sociocultural needs and experiences. The culturally competent therapist is also continually attuned to factors (both interpersonal and intrapersonal) necessary for fostering the therapeutic relationship (e.g., cultural empathy, humility, self-awareness).

Future Research

The proposed model is the first of its kind to elucidate theoretical principles that explain the mechanisms of cultural competency. Though its tenets are based in evidence and scholarly work from years of cultural competency literature, future research is needed to directly and empirically test these principles as mediating variables in the process of cultural competency in psychotherapy.

In order to effectively assess and implement the three theoretical principles presented in this article, treatment outcome research should be conducted to examine the principles' clinical utility when implemented separately and in combination. Most examinations of cultural competency approaches focus on an isolated construct (e.g., ethnic/language matching) rather than exploring a synthesis of principles (Brach & Fraser, 2000). Future outcome research should assess clients' therapeutic engagement, symptom reduction, and retention when therapy incorporates the three principles individually (i.e., focusing on the contextual match with clients' external realities) and in combination (i.e., using all three cultural competency principles with one client, as described in the case example). It will be particularly interesting for studies to investigate whether integration of all three principles facilitate the strongest therapeutic utilization and outcomes. In addition, given the particular importance of effectiveness research that translates efficacy research for real-world application with ethnic minority or other underserved populations, future work is needed to investigate the most appropriate and effective approach for implementation of the three principles.

Conclusion

Overall, the present article presented a synthesis and advancement of the cultural competency in psychotherapy literature. Our theoretical model of cultural competency unifies a broad and variegated cultural competency and psychotherapy literature, and provides a common foundation for understanding the basic principles and mechanisms of culturally competent psychotherapy. These theoretical principles contextualize existing research on essential components of culturally competent treatment, and provide guidance for much-needed research on the mediating mechanisms of cultural competency on treatment outcome.

Clinicians can utilize the theoretical principles to determine the most appropriate approach for clients from multiple intersecting cultural identity backgrounds. It is also possible that these three principles can be combined to improve clinical engagement, treatment retention, and/or therapeutic outcomes. For example, therapists working with minority clients who feel alienated interpersonally may pay particular attention to skills in cultural empathy and self-awareness to foster their clients' sense of being understood. Providers whose clients face multiple minority stressors may focus on matching treatment structure and content to the social or economic needs of their clients' external reality context.

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