

Health Care Disparities and Training in Culturally Competent Mental Health Counseling: A Review of the Literature and Implications For Research

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Abstract

Cultural competency has been lauded as an effective, direct intervention to address health care disparity issues, and there is much empirical and clinical evidence to support the utility of cultural competency training. The major criticism of this evidence is the paucity of content validation studies of the competency construct itself. This literature review addresses what has been repeatedly identified as a critical empirical need – clarification of the cultural competency process in the professional development of mental health care providers working with health care disparity populations. In this literature review, the proposed concept of cultural attunement has 5 elements that signify a relevant skills training model for developing multicultural sensitivity and awareness. The call for research is clear: the cultural attunement concept needs to be operationally defined and measured, which can then lead to the design of a training model directed at enhancing the cultural competency performance of mental health counselors.

Key Words: counseling relationship, culturally attuned counseling, cultural competency, cultural competency training, health care disparities.

1. Introduction: Mental Health Disparities and Counselor Training

With the advent of a national healthcare disparities policy (US Department of Health and Human Services, 2000), public health care organizations have been given direct responsibility for the professional training of their counseling staff in cultural competency. While training programs have been developed based on major cultural competency theories and cultural competency construct descriptions (Pope-Davis, Coleman, Ming-Lui, & Toporek, 2003; Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003; Sue et al., 1998; Tseng, 2004), it is not known whether the training is comprehensive or effective. It is argued here that there is a present challenge to cohesive theory and consistent validation studies in cultural competency training, particularly as they apply to health care disparities (D'Andrea, 2000; Egede, 2006; Hansen, 2005; Sue & Sue, 1977; Sue & Zane, 1987; Vega, 2005).

While a number of contemporary training models seek to address competency in multicultural counseling (MCC), there is an acknowledged, current need to ground these models in theory and documented practice; to clearly define and validate the competency concept; and to clarify, through elemental constructs, the inherent complexity of acquiring competency (Mollen, Ridley, & Hill, 2003). Further, while the tripartite schema for MCC competency may currently dominate training models, there is persistent and emerging theoretical research that points to an ever increasing complexity and multidimensionality of multiculturalism which includes not only attributes of the counselor and the counseling relationship but also counseling organizations, communities, and societal institutions as well (Betancourt, 2006; Cooper, Beach, Johnson, & Inui, 2006; Sue, 2001; Toperek & Reza, 2001; Vega, 2005). Therefore, there seems to be a critical empirical need – clarification of the cultural competency process in the professional development of mental health care providers who do psychotherapy with clients from health care disparity populations (Draguns, 2004; Escarce, 2005; Feltham, 1999; Fiscella, Franks, Gold, & Clancy, 2000; Hansen, 2005; Mollen et al., 2003; Sue & Zane, 1987; Tucker, Daly, & Herman, 2010).

2. Mental Health Disparities and Cultural Competency Training

In the 2001 supplemental report, “Mental Health: Culture, Race, and Ethnicity” (U.S. Department of Health and Human Services), the Surgeon General charged the National Institute of Mental Health (NIMH) with improving the quality of care in mental health services through ensuring evidence-based treatment, and developing and evaluating culturally responsive services.

The report acknowledged the paucity of empirical studies on cultural competence and invited very specific research examining “. . . the capacity of the provider to convey understanding and respect for the client’s worldview and experiences” (p.166). An obvious, expected first step in empirically examining the ‘capacity . . . to convey understanding and respect’ is to operationally define the concept, and empathy appears, initially, to be the definitive process by which this ‘capacity’ is measured. However, as is established in the literature review that follows, empathy alone is not sufficient, but the counseling relationship itself which includes empathy (Bohart & Greenberg, 1997; Miville, Carlozzi, Gushue, Schara, & Ueda, 2006; Pedersen, Crethar, & Carlson, 2008) is likely to be definitive of the ‘capacity’ with which NIMH is empirically concerned. Furthermore, it is proposed here that the counseling relationship as defined by the process of cultural attunement (Hoskins, 1999) will provide the theoretical basis for defining and ultimately measuring NIMH’s concept of culturally responsive and competent counseling ‘capacity.’

Currently, in clinical practice settings, cultural competency training has been accepted largely based on the face validity of models of cultural competency alone; and these models, in turn, have been widely and directly adapted to in-service training programs that address health care disparities in service delivery systems. For the most part, cultural competency training has been policy-driven as directed by the US Department of Health and Human Services (DHHS) in its two volume publication, *Healthy People 2010* (DHHS, 2000; now succeeded by *Healthy People 2020*) as well as by the guidelines outlined in the DHHS Office of Minority Health report on national standards for culturally appropriate health care (DHHS Office of Minority Health, 2000). It is argued here that cultural competency training for counselors should reflect a specific, theory-based praxis that offers clear parameters for assessing training effectiveness.

3. The Evolution and Validation of the Cultural Competency Construct in Counseling

To understand the general lexicon used in this literature review, it is helpful to provide a brief definition of the 3 key terms discussed: culture, competence, and cultural competence. Citing the DHHS Office of Minority Health to support the clinical understanding of the social determinants of health, the Centers for Disease Control and Prevention define the 3 terms accordingly:

Culture is the blended patterns of human behavior that include ‘language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.’ *Cultural competence* is ‘a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.’ ‘*Competence*’ in the term cultural competence implies that an individual or organization has the capacity to function effectively ‘within the context of cultural beliefs, behaviors, and needs presented by consumers and their communities.’ (Centers for Disease Control and Prevention [CDC], retrieved 4/25/2011).

These stated definitions, derived from research, professional practice, and tradition, undergird the conceptual basis for cultural competency training in mental health.

3.1 Cultural competency in counseling: A historical perspective. As indicated above, there is a historical and empirical basis for the general acceptance of cultural competency training in mental health. In the foundational years of MCC competency theory-building, Pederson’s (1987) classic “10 assumptions of cultural bias” followed by Sue and Sue’s (1977) “barriers to effective cross-cultural counseling,” which came after Wrenn’s (1962) ground-breaking “culturally encapsulated counselor,” all helped to make what is now the well-established case that counseling has been historically culture-bound. Subsequently, researchers sought to identify the components of cultural competency, which led to the traditional tripartite theory of MCC competency (i.e. cultural awareness, knowledge, and skills; see Arredondo & Toporek, 2004; Arredondo et al. 1996; Ibrahim, 1999; Mollen et al., 2003; Roysircar, Hubbell, & Gard, 2003; Sue et al., 1998).

It appears, however, that the developmental history of MCC laid the groundwork for multicultural competency training models to become a professional and organizational panacea for health care disparities (Vega, 2005). The ready acceptance of cultural competency training in the health care community was based more on its seeming expediency in addressing the immediate national concern with health care disparities than on its clear theoretical and empirical grounding. Vega (2005) described the difficulty of addressing the huge problem of health care disparities with a single, still evolving tool – cultural competency. He believes that the increasing mandatory emphasis on culturally competent service in health care requires the proponents of cultural competence to place renewed and immediate emphasis on clarifying their mission and their methods.

Despite limited construct validation studies, the 3 domains of the tripartite MCC competency model are now supported – individually and together (McFadden, 1999; Pope-Davis et al., 2003) – by a broad range of empirical findings, and these competencies are considered to be the standard guidelines for teaching and training in the profession of multicultural counseling (Roysircar et al., 2003; DHHS Office of Minority Health, 2000). Yet, both the tripartite and later models (*see* Sue, 2001) still remain unvalidated as whole systems. Others have argued that there are primary domains missing from the competencies or that the prevailing domains are very difficult to empirically validate. For example, Sue and Zane (1987) observed that gaining complete cultural and ethnic knowledge about every client is an impossible task; and Roysircar-Sodowsky, Taffe, Gutman and Wise (1994) proposed the “counseling relationship” as a distinct fourth domain to be included in the original tripartite model.

Given the empirical and professional concerns about the cultural competency construct and its related training as described above, the following literature review will recognize a distinct research need specifically identified by healthcare policy makers and cultural competency scholars alike. This review will also examine how cultural competency becomes a durable part of professional identity and will explore the cited processes of necessary personal change that contributes to developing this identity. More specifically, the following review will (a) highlight the significance of the relationship between disparities in health care and clinical cultural competency; (b) evaluate how competency is acquired; (c) make an important distinction between the cultural content of competency and the processes of counseling competency; (d) demonstrate that competency is driven by the relational processes of counseling which, in turn, support culturally competent skills; and (e) identify the critical relational attributes of the multicultural counselor.

3.2 Health Disparities and Clinical Cultural Competency. The scope and extent of disparities in health care delivery systems have been clinically, statistically, and empirically documented (Betancourt, 2006; Escarce, 2005; Fiscella, Franks, Gold, & Clancy, 2000; Siegel, Moy, & Burstein, 2004; Steinbrook, 2004), establishing the fact that minority populations tend to confront systemic biases in their access to health care services and are exposed to unequal treatment compared to their Caucasian counterparts. In the specific case of mental health, evidence of disparities in mental health service delivery has also been amply documented (Brown & Bradley, 2002; Danzinger & Welfel, 2000; Moodley & Palmer, 2006; Perloff, Bonder, Ray, Ray, & Siminoff, 2006; Richardson, Anderson, Flaherty, & Bell, 2003; Rogler, Malgady, Costantino, & Blumenthal, 1987; Sturm, Ringel, & Andreyeva, 2003; Vontress, 1976) in all phases of counseling, including intake, diagnosis, treatment, and outcomes. Multicultural competency has been lauded as an effective, direct intervention to address the disparity issues at community, organizational, and individual levels (Arredondo & Toporek, 2004; Arredondo et al., 1996; Burnett, Hamel, & Long, 2004; Choudhuri, 2003; Lillie-Blanton & LaVeist, 1996; Pope-Davis et al., 2003) through special community outreach services, organizational development through policy and procedure review, and specialized professional development training of counselors. There is much empirical and clinical evidence to support the utility of cultural competency training (Auger, 2004; Barrett & George, 2005; Fuertes et al., 2006; James & Foster, 2006; Kiselica, 1999; Mollen, Ridley, & Hill, 2003), but a major criticism is the paucity of validation studies of the competency construct itself (Coleman, 2004; Coleman & Wampold, 2003; Mollen, Ridley, & Hill, 2003; Patterson, 2004; Pope-Davis, Coleman, Ming-Lui, & Toporek, 2003; Thomas & Weinrach, 2004; Vontress & Jackson, 2004; Weinrach & Thomas, 2004).

3.3 Acquisition of Cultural Competency. It is believed that part of the difficulty in validating the competency construct is due to an important omission in defining how cultural competency is acquired. As Yan and Wong (2005) have declared in their assessment of the cultural competence literature, the basic abilities for self-awareness and insight needed for cultural competency is “taken for granted” or assumed to preexist in empirical and clinical studies. Similarly, Roysircar-Sodowsky, et al. (1994) have indicated there is a higher order domain of competency – beyond the basic knowledge, skills, awareness, and counseling relationship domains – that has yet to be empirically defined.

3.4 Cultural Content versus Counseling Process in Cultural Competency. Further, there is even less empirical clarity about the process of personal developmental change from the culturally non-competent counselor to one who is competent (Feltham, 1999; Lorion & Parron, 1985; Norton & Coleman, 2003; Yan & Wong, 2005). However, there is much empirical support for the primacy of the process in the therapeutic relationship of effective MCC (Draguns, 2002; Leininger, 1985; Pedersen et al., 2008; Ridley & Udipi, 2002; Russell, 1999), and many of the key, therapeutic elements that define an effective counseling relationship have been empirically documented in effective MCC interventions as well (Agnew-Davis, 1999; Constantine, 2001; Vera, Speight, Mildner & Carlson, 1999).

Consistent with Roysircar et al. (1994), it appears that the basic tripartite model addresses the *cultural content* of competency, but not its *process of counseling*. Distinguishing between content and process is important in defining the foundational *process* elements of a culturally competent therapeutic relationship (see McLeod, 2006; Pedersen et al., 2008; Plummer, 1997; Roysircar, Hubbell, & Gard, 2003; Sue & Zane, 1987). In considering this distinction, Sue and Zane (1987) conceived of a continuum between therapeutic emphasis and treatment goal. They recognized that knowledge of culture or *content* seemed likely to be the most distant from the treatment goal while the proximal *process* of therapist credibility and client's perception of benefit received seemed closest to the treatment goal on the continuum. This supports the conceptual idea that process informs content (*see also* Bateson, 1979; Grandy, 1996; Ruesch & Bateson, 1951; Rychlak, 1997). Therefore, it seems that to the extent that the therapeutic "process" factors of competency can be validly delineated, it is believed to that extent the content of competency can be further defined and validated.

3.5 Relational Counseling Processes and Culturally Competent Skills. Through her explication of cultural attunement, Hoskins (1999) has provided a basis for addressing the conceptual and empirical discussions (Patterson, 2004; Sue & Zane, 1987; Thomas & Weinrach, 2004; Vontress & Jackson, 2004; Weinrach & Thomas, 2004) centered round the validity and relevance of cultural competencies, along with the inconsistent evidence of matching ethnicity and race. Hoskins's 5 concepts of cultural attunement specify the qualities of the culturally competent *relationship* in counseling. As a caveat and for the sake of clarity, Hoskins's construct of attunement is complimentary to, but not conceptually a part of the relational theory of treatment in multicultural counseling (*see* Comstock, Duffey, & St. George, 2002; Robb, 2006).

Hoskins (1999) described how her disciplined subjective experience helped her to arrive at the cultural attunement construct by focusing on the 'relational processes' of multicultural counseling. She personally and professionally reflected on how these qualities made her most effective when, as an individual from the mainstream culture, she engaged those whose lived realities were different from her own. The concept of cultural attunement is explored more in depth under the topic, *Hoskins's 5 Cultural Attunement Concepts*, below.

In considering, further, the distinction between technical "content" and relational "process", McFadden (1999) asserted, "Technical competence, although required to teach skills, is insufficient without the interpersonal link essential to establishing effective communication between counselor and client" (p. 13). There are a number of empirical voices which acknowledge the importance of intercommunication dynamics within the multiculturally competent counseling relationship, and by inference, the primacy of *process* through communication within that relationship (McFadden, 1999; Pedersen et al., 2008; Roysircar, Hubbell, & Gard, 2003; Sue, 2001). Research has demonstrated that it matters little about the effectiveness of techniques in specific orientations, but more about factors common to all counseling orientations and that the single most important factor is the "quality of the counseling relationship" (Hansen, 2005, p.216; *also* Pedersen et al., 2008). Further, there is significant evidence that the nature of client and counselor variables and the relationship between the two, predict positive treatment outcomes more so than specific theory and counseling interventions (Collins & Arthur, 2005). Similar to Roysircar-Sodowsky, et al. (1994), Collins and Arthur (2005) have argued that the fundamental ideas of cultural competency – knowledge, awareness and skills – are meaningful to the counseling process only within the context of the counseling relationship.

There has been a recent concern in *multicultural* counseling research with the importance of the social, cultural, and historical context of the counseling relationship, especially as it relates to counselor authenticity, transference and countertransference, racial-ethnic matching of client and counselor, and the working alliance (Choudhuri, 2003; Pedersen et al., 2008). Related to this, health care disparities research supports the significance of the prescriptive doctor- patient relationship and has identified 5 relationship process mechanisms for this relationship: partnership, respect, knowing, affiliation/liking, and trust (Cooper et al., 2006). This particular research has linked the effectiveness of the 5 mechanisms to the racial, ethnic, and/or socioeconomic background concordance of the practitioner and patient; the racial and ethnic concordance of practitioners with peers; and the degree to which practitioners are self-aware of their personal biases, stereotypes, and attitudes. This research also affirmed the important role of specific practitioner relational processes in therapeutic relationship development. Similar research supports the expectation that relationship-centered care can reduce diagnostic and treatment disparities, and that enhancing the practitioner's self-knowledge is strategic to improving the doctor-patient relationship (Cooper et al., 2006).

Further, it appears that successful multicultural counseling outcomes seem to depend most upon the positive experience of meaning that clients perceive as a result of the interaction between those sociocultural factors that directly influence the counseling relationship, particularly those interactions involving the counselor (Choudhuri, 2003). Lastly, recent and emerging cultural competency research is beginning to emphasize and attend specifically to counselor effectiveness in the MCC relationship (Connery & Brekke, 1999; Christopher & Smith, 2006; Fuertes et al., 2006; Hanna, Bemak, & Chung, 1999; Harper & Stone, 1999; Hinkle & Hinkle, 1995; Pedersen et al., 2008; Plummer, 1995).

3.6 The Critical Relational Attributes of the Competent Multicultural Counselor.

In examining the available literature, it was particularly important to identify those reported features of the multicultural counselor that seem most effective when *relating* therapeutically with multiethnic clients. There is a consistent, generally prevailing, view in the literature that Carl Rogers's client-centered legacy dominates the way of being that a counselor is expected to exhibit when counseling across cultures (Choudhuri, 2003). Further, there is the more traditional understanding that in order to establish a trusting, nonjudgemental counseling alliance, clients must feel accepted and understood. Affiliation or "liking" is acknowledged to be a key influence in clinician effectiveness yet available evidence has pointed to an automatic, affect disconnect between clinicians and their minority patients (Cooper et al., 2006). When clinicians did not like their clients, they were prone to provide differential treatment and poorer medical care. This affective "disconnect" is predictable according to the sociology of group participation where group members tend to connect with persons who are most similar to them. Further, trust has been widely cited as a paramount factor in interpersonal care relationships and mistrust is prevalent in dominant clinician- minority patient care situations (Cooper et al., 2006).

In the more specific case of clinical mental health care, it is critical to pay attention to the so-called relationship-centered attitudes and behaviors of communication, partnership, respect, knowing, affiliation, and trust in order to establish a productive therapeutic alliance (Pedersen et al., 2008). Yet, it has been indicated in mental health care disparities literature (Brown & Bradley, 2002; Danzinger & Welfel, 2000; Moodley & Palmer, 2006) that without coming to terms with how the negative poles of these positive attitudes and behaviors play a covert role in multicultural psychotherapy, minority clients will continue to avoid mental health treatment.

In one literature review (Erdman, 2002), two definable counseling processes were listed by which clients obtain acceptance and understanding: "joining" and "intimacy." Joining was described as a "meta-technique" which referred to a specific quality of counselor attitude toward clients rather than skill; and intimacy referred to a quality of counselor interaction in the counseling relationship which went beyond the overt expression of warm and close feelings toward clients. Joining and intimacy enable counselors and clients to co-create more therapeutically effective meaning within the counseling relationship. It appears that, implicit in the cultural attunement development of counselors, is the capacity to 'join' with culturally diverse clients compassionately and to demonstrate a level of intimacy with these clients through the process of mutuality. While these "higher-order" (ie. beyond measurable technical skill) counseling abilities are seen as indispensable when working competently with multicultural clients, it is acknowledged that cultivation of these abilities is a life-long proposition, best accomplished through continual cultural self-awareness which is then adapted to the needs of the counseling relationship (Plummer, 1997).

Even so, it is necessary to be conceptually and empirically succinct about what self-awareness means (Landrine, 1995). Accordingly, Yan and Wong (2005) state: "We contend that the cultural competence model's *taken-for-granted* (emphasis added) notion of cultural awareness, which is a form of self awareness that focuses particularly on one's cultural background, is conceptually incoherent" (p.181). Yan and Wong contend that competent therapists can be truly self-aware only through a mutual dialogue with their clients and that therapists can gain real understanding of their clients only by entering their clients' worldview and adjusting their own worldview accordingly. This perspective lies at the heart of Hoskins' (1999) conceptualization of cultural attunement and is also consistent with what Augsberger (1986) has named "interpathy" – where counselors intentionally join the subjective world of their clients – and with Roysircar's (2006) "ethnotherapeutic empathy."

It is acknowledged that it is difficult for mental health counselors to recognize their implicit assumptions and how their unacknowledged negative assumptions influence their approach to assessment, diagnosis, and treatment. Adult assumptions about human nature typically becomes fixed in adolescence; yet, counseling theory teaches that the self of the therapist is the most critical instrument of change in therapy (Auger, 2004).

Despite the relative entrenched character of attitude development, research suggests that implicit assumptions of counselors can be made explicit through focused self-reflection, custom training, and sensitive supervision (Auger, 2004). Additionally, existing research (Ibrahim, 1999; Pope-Davis et al., 2003; Sue et al., 1998) has indicated that the cultural and racial identity development of the counselor also will contribute significantly to the degree to which the counselor can become fully self aware, and by inference, fully culturally attuned and competent. Further, the cultural attunement process as conceived by Hoskins (1999) could potentially augment and enrich the counselor's cultural identity development.

4. Hoskins's 5 Cultural Attunement Concepts

Hoskins's (1999) elegant, but simple, construct of attunement can provide the theoretical and foundational basis for validating 5 specific and interrelated dimensions of quality in the relationship skills of cultural competency. A first step in future research is to operationalize the attunement dimensions. For this review, rudimentary definitions of the attunement dimensions, including Hoskins's original descriptions, are provided in definitions below.

4.1 Cultural Attunement Dimension I – Acknowledge the pain of cultural oppression. This concept may be identified as the dimension of *cultural insight*. The cultural insight concept, as defined by Hoskins (1999), is consistent with empirical evidence supporting direct experiential learning in MCC competency training (Constantine, 2001; Lee, 2006; Miller, 1999; Roysircar et al., 2003; Roysircar, Hubbell, & Gard, 2003). This concept is also aligned with the clinically and professionally accepted guidance that MCC should be sensitive to the legacies of societal racism, oppression, and discrimination (Kiselica, 1999; Ridley, 2005). The cultural insight dimension is named for Hoskins's emphasis on the need to teach counseling students directly about the lived experience of those who suffer oppression.

4.2 Cultural Attunement Dimension II – Acts of humility. This concept may be identified as the dimension of *cultural acceptance*. In contradistinction to the understanding that humility is just another name for humiliation, this concept more accurately describes the ability to maintain a balanced perspective about one's talents, successes and failures. Templeton (1997) explains that humility is not self-deprecation, but rather, it represents wisdom and is the opposite of arrogance. To be sure, humility is not without spiritual and religious underpinnings (Sandage, 1999; Sandage & Wiens, 2001; Sandage, Wiens, & Dahl, 2001; Strunk Jr., 1995) and positive psychology classifies it as a virtue of character (Peterson & Seligman, 2004; Tangney, 2000). In reference to cultural attunement, Hoskins (1999) addresses humility in this fashion:

Control, restraint, temperance and modesty are all synonymous with the concept and experience of humility. . . . In order to be truly humble a person must make him or herself vulnerable to reaching forward into the space between self and other . . . without a guarantee of reciprocity [which] takes courage and a willingness to abandon the need for social comfort. (p. 79)

4.3 Cultural Attunement Dimension III – Acting with reverence. This concept may be identified as the *cultural esteem* dimension. The only similar psychological conceptualization of this dimension that was found in the literature was proposed by Cowan and Presbury (2000) where they defined reverence as a special adaptation of Carl Rogers's definition of person-centered empathy. Hoskins (1999), however, defines reverence both in empathic terms, and in terms of distinguishing clearly between respecting clients and revering them. She states:

Respect for difference is often listed as an essential quality when working with cultural diversity. But the word *respect* is problematic because it implies judgments and approval rather than total acceptance On the other hand, reverence for another has different implications for being in relation with others. Instead, esteem, honor, regard, worship, and awe are synonymous with the word reverence and offer a different way of thinking about another person's experience. . . . Reverence requires a person to think, act, and listen from the heart, and bring forth feelings of wonderment and awe concerning how another person has created the meaning of his or her life. (p. 80)

From the perspective of this review, reverence is seen to be the spiritual core of cultural attunement and appears to be a unique conceptual contribution by Hoskins to the multicultural counseling literature. It would seem that a reverent orientation toward clients will enable multicultural counselors to successfully cultivate Hoskins's other 4 processes of attunement, which in turn, will specifically enhance the counselors' overall multicultural counseling competence.

4.4 Cultural Attunement Dimension IV – Engaging in mutuality. This concept may be identified as the dimension of *cultural kinship* and also appears to be a unique conceptual contribution to the multicultural counseling literature by Hoskins (1999). Hoskins's description of this dimension seems to reflect her specialized understanding of multicultural empathy. According to Hoskins, "Mutuality occurs when two people come together to share common experiences. It is a feeling of closeness which means that despite many differences, there is a feeling of connection when two human beings began to develop a relationship. . ." (p. 80-81). Hoskins observes further that persons who have lived with oppression feel anger when the value of their cultural differences are minimized or ignored. Persons from the dominant culture need to recognize and appreciate the diversity in different cultural value systems while also seeing and appreciating the commonalities between cultures. This dimension is directly consistent with the understanding of etic and emic counseling perspectives within the tripartite cultural competency model (Pope-Davis et al., 2003).

4.5 Cultural Attunement Dimension V – Capacity to "not know". This construct may be identified as the dimension of *cultural openness*. Erdman (2002) captures the underlying import of maintaining a position of not knowing, stating: "Clients are the true 'experts' on their lives. Using the 'not knowing' position allows counselors to tap into the expert knowledge that clients possess" (p. 37).

"Not – Knowing" is a term first applied by Anderson and Goolishian (1992) and is rudimentary to the basic helping relationship in counseling. Anderson and Goolishian declared that the counselor must cultivate attitudes and actions that communicate "... abundant, genuine curiosity" (p.29).

Hoskins (1999) makes a clear statement about the implied humility in operating from a place of 'not knowing' in multicultural communication:

... Those who "assume they know" often make the mistake of glossing over the uniqueness of another's experience without fully considering or understanding personal meanings. Rather than fostering connection, such an all knowing positioning can result in disconnection instead. Human understanding is always provisional, open to present and future change. In relationships, rather than seeking certainty, closure, and control, we must be tentative, experimental and open-ended . . . Dominant cultures have for too long believed they "know" based on their own ethnocentric worldview, not the perspective of others" (p. 81-82).

As one considers Hoskins's (1999) cultural attunement dimensions, ideal elements of human nature – such as compassion, love, empathy – are readily apparent as being the basis for her attunement qualities. Fortunately, for the mental health profession, these ideals are considered foundational elements of ethical practice. And yet, the ideal does not always translate into actuality. For the purposes of research, it will be useful to operationally define the elements of cultural attunement from both a practice and an applied spirituality perspective. From the practice point of view, attunement should be translated within existing standards of practice. From the applied spirituality perspective, the spiritual dimension is seen as an integral part of the cultural lives of counselor and client alike (Miller, 1999; Strunk Jr., 1995) and it needs to be included in the explicative function of future research.

To conclude, Hoskins's 5 cultural attunement dimensions are proposed not as original theoretical concepts, but as specific adaptations of discrete professional counselor identity variables that are unique to the requirements of multicultural counseling. Further, it is believed that these 5 dimensions may provide a cohesive, holistic system for helping to define counselors' effectiveness in multicultural competency.

5. Specific Literature Review Implications for Cultural Attunement in Multicultural Counseling.

In this review of the available literature, there was an attempt to find research that supports Hoskins's (1999) vision of a holistic approach to relating effectively across cultures. While there are many references in the literature about the qualities of the successful multicultural counselor (Arredondo et al., 1996; Burnett et al., 2004; Collins & Arthur, 2005; Constantine, 2001; Davis, 1983; Draguns, 2002; Fuertes et al., 2006; Heid & Parish, 1998; Hinkle & Hinkle, 1995; Lee & Ramsey, 2006; Leininger, 1985; Ridley & Udipi, 2002; Rogler et al., 1987; Sevig & Etkorn, 2001; Snyder & Ingram, 2000; Walz & Yep, 2005), there were no documented models for training counselors in what Hoskins has named cultural attunement. There has been, however, a distinct call in the literature to explore a new paradigm entitled, "the culturally responsive counselor" (Lee, 2006; Lee & Ramsey, 2006). It appears that the concept of a culturally responsive counselor has been recognized by the field of the emerging need to define the next evolutionary stage of MCC competency.

Lee and Ramsey (2006), who promote the concept of culturally responsive counseling, applaud the achievements of the multicultural movement in counseling, but also argue for the expansion of the notion of what it means to be a “culturally responsive counseling professional” (p. 7) and the concomitant expectations for professional cultural competency. As with any proposed changes to a paradigm, there are observable challenges to be met in producing the changes. Specifically, Lee and Ramsey (2006) have noted a particular challenge with addressing the gap between the perceived cultural competence in counselors and their actual competence. They have observed:

. . . As multicultural counseling continues to question the validity of traditional counseling practice with diverse groups of people, there is a danger that professional counselors will become self-conscious about their level of competence to work with diverse clients. A question often asked by counselors in a frustrated tone is “How can I really be effective with a client whose cultural background is different from mine?” . . . [Similarly, a] sentiment often expressed by counselors on the front lines of multicultural service delivery is the need for less theory and more practical direction for addressing client concerns in a culturally responsive manner. (pp. 8,9)

This gap between practice and self-perceived competency is important, and research is needed to address this gap – a gap that seems to have resulted from the lack of empirical attention to the imputed or latent dimensions of attunement which have been assumed to be part of the competency building process. It is argued that in much of the cultural competency literature there are specific, unarticulated assumptions about the ability of counselors to become culturally responsive. There seems to be “givens” assumed about the character and personal philosophy of the counselor toward different cultures that are not justified because they have not been made explicit elsewhere –neither in professional identity development nor in professional ethical code and conduct. In this way, *the cultural competency literature has omitted a prime ingredient for counselor competency – the counselor’s attitudinal and psychological receptivity to becoming culturally responsive.* Any future research on cultural attunement that attempts to address this omission, in some measure, will then address the frustration counselors feel about their effectiveness when doing actual multicultural counseling.

Of the relevant literature reviewed here, Roysircar’s (2006) ethnotherapeutic empathy concept is one of the very few identified that seems to come nearest in meaning to Hoskins’s conceptualization of cultural attunement. As cited previously, the ethnotherapeutic idea followed logically upon Roysircar’s earlier research with colleagues where they have proposed a fourth domain to be added to the foundational tripartite model – the multicultural counseling relationship itself (*see* Roysircar-Sodowsky et al., 1994). Further, there is important empirical evidence aligned with Roysircar-Sodowsky et al.’s (1994) theoretical domain of the MCC relationship (Chodorow, 1999; Feltham, 1999; Fuertes et al., 2006; Ibrahim, 1999). This empirical evidence has contributed to a concept which defines the “culturally competent working alliance” as the counselor’s ability to establish culturally sensitive rapport, to communicate openness and receptivity, to identify the influence of oppression and discrimination, and to sensitively process differences in race and culture (Fuertes & Ponterotto, 2003). Similar to the ethnotherapeutic empathy concept, the definition of the culturally competent alliance seems to align very closely with the cultural attunement construct. Like cultural attunement, however, neither of these two concepts have been empirically validated as holistic models.

6. Conclusion

To conclude, it is believed the concepts of culturally responsive counseling and the culturally competent alliance, along with Hoskins’s (1999) proposed construct of cultural attunement, point directly to the empirical and practical need to understand how specific processes related to the professional development of the counselor within the MCC relationship contribute directly to the counselor’s overall cultural competency effectiveness. It seems that succinctly defining the relationship between counselors’ multicultural professional development and cultural competency acquisition may also specifically contribute to validating the competency construct. Therefore, it is argued that cultural attunement is an integrative construct that may bring together several theoretical positions that support the necessity of self-reflection, empathy, and on-going self-development in culturally competent counselors. Specifically, the 5 dimensions of cultural attunement as presently described appear to be applications of two valued attributes that all effective counselors must traditionally possess – empathy (acceptance) and insight. In addition, there are three more *essential* attributes apparent in the cultural attunement construct that may or may not have been traditionally cultivated by counselors who practice cultural competency – humility, mutuality, and transparency or openness. It is believed that cultivation of all 5 cultural attunement dimensions will be strategic to effective MCC competency and future research can establish the attunement construct as an important element in the existing knowledge base on cultural competency.

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