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Culturally Congruent Practices in Counseling and Psychotherapy: A Review of Research

As demonstrated across the chapters of this *Handbook*, the field of multicultural counseling and psychology is varied and complex. However, to simplify and generalize, one of its foundational assumptions is that cultural contexts exert profound influence on individuals and their mental health. More concisely, culture counts (U.S. Department of Health & Human Services, 2001).

Even skeptics of multicultural psychology acknowledge the influence of culture. However, they do question its salience with respect to mental health practices (e.g., Patterson, 2004). If psychotherapy can be effective without attending to cultural contexts, why bother with multiculturalism? Can we avoid stereotyping/mistreating individuals when we emphasize cultural collectives? Are not many intra-psychic factors (childhood experiences, family dynamics, reinforcement history, irrational cognitions, etc.) more relevant to mental health than macro-level cultural contexts? From such a perspective, culture counts, but not as much as individual-level factors.

Tension in the broader profession results from these divergent perspectives regarding the salience of multiculturalism. Should cultural considerations be primary (equivalent to other components of mental health interventions, including individual-level factors) or secondary (non-equivalent to individual-level factors, which are the focus of traditional mental health interventions)? This distinction is neither subtle nor trivial. It concerns the very foundation upon which mental health interventions are designed and implemented. If cultural considerations are primary, then contemporary mental health

interventions require revision to better meet the needs and experiences of clients not aligned with Western worldviews–and new interventions specific to diverse cultural groups are needed. Thus the debate often centers on how to best serve ethnic minority clients not acculturated to European American society. For such populations, what constitutes an effective mental health intervention?

Much of the confusion about and polarization between multicultural and traditional approaches may be attributable to the historically sparse research literature specific to ethnic minority groups (S. Sue, 1999; S. Sue et al., 2006). However, during the past decade adequate research evidence has accumulated to the point that substantive questions may be posed of the literature. Empirical research, although not unflawed, is seen as the arbiter of professional debates, such as the efficacy of psychotherapy and the role of cultural variables in psychotherapy (primary or secondary). Given this state of affairs, one of the most decisive research questions that could be posed is: *Are mental health interventions that are intentionally made congruent with clients' cultural contexts more effective than traditional practices?* If a large body of empirical data supports an affirmative response to this question, then multiculturalism may be deemed not only legitimate within but integral (primary) to mental health interventions. However, if the data are inconclusive or deemed inadequate, then multiculturalism will remain marginalized (secondary) as an egalitarian ideal, possibly worthy of public praise but privately labeled as "impractical" or worse. All other things being equal, empirical evidence should determine which path will be taken; this chapter will attempt to provide direction.

Mental Health Interventions: The Need for Culturally Congruent Practices

At a basic level, counseling and psychotherapy include three components: the therapist, the client, and the intervention enacted in the context of the client-therapist relationship. Traditionally, the focus of counseling and psychotherapy research has been upon the efficacy and effectiveness of the intervention itself (e.g., competing theoretical paradigms, managed care), with relatively less attention given to characteristics/abilities of the therapist or to expectations/resources of the client (Atkinson, Bui, & Mori, 2001). Current emphasis on empirically supported treatments (ESTs) reflects the larger trend: Thousands of research studies investigate nuances of treatment, while studies of therapist competence or client resource networks receive less attention.

An opposite trend characterizes the multicultural literature, which has attempted to fill the gaps in the traditional literature by explicitly emphasizing therapist factors (i.e., multicultural awareness, knowledge, and skills) and client factors (i.e., acculturation, ethnic/racial identity, experiences with discrimination). The contributions of the multicultural literature in raising awareness of those areas are groundbreaking, but the impact upon counseling and psychotherapy interventions in practice settings has been less prominent. This chapter asserts that applying the principles of multicultural psychology can lead to improved mental health interventions. Although in any approach the components client, therapist, and intervention necessarily overlap, this chapter focuses discussion on intervention factors that are less emphasized in multicultural literature.

What constitutes culturally congruent practice? Culturally congruent practices in mental health interventions are consistent with clients' conceptualization of the problems, means for solving problems, and goals regarding outcomes (S. Sue, 1988). Such

practices include providing services in clients' preferred language, modifying the length/frequency of sessions, utilizing culturally congruent terminology and concepts, involving family members or friends, consulting with persons familiar with a client's culture to facilitate accurate understanding, etc. A specific example would be a treatment program for Native Alaskans based on that population's cultural concepts, integrating traditional healing practices (Fisher, 1996).

Because such practices go beyond what is typically provided in traditional counseling and psychotherapy, they are commonly referred to as "cultural adaptations" to treatment. Nevertheless, scholars promoting multicultural competency contend that therapy should involve such practices as a matter of course (Arredondo & Toporek, 2004; Pedersen, 1990). Hence rather than referring to "adaptations," a term which may imply exceptions or unusual effort, this chapter uses the term *culturally congruent practices* (see also the related term *ethnocultural psychotherapy*; Sue, 2000).

Why address macro-level cultural variables in mental health interventions for individuals? Provision of culturally congruent practices is based on an assumption that clients will experience greatest improvement when they understand and value the interventions provided in therapy. For example, in most cases clients may value a humanistic, conversational approach to therapy, but in some cases the normative expectations regarding "professional help" involve receiving prescriptive advice to resolve dilemmas (e.g., Zane, Morton, Chu, & Lin, 2004). The effectiveness of therapy thus depends on the utilization of existing client worldviews and on client readiness to engage in change through certain ways over others.

To put this concept into perspective, it may be helpful to put ourselves in the place of the client. On experiencing distress and seeking assistance from a mental health provider, which would we find most helpful: treatment that required us to adapt to the worldview of the professional or therapy in which the professional worked within our own worldview? Although the optimal solution might actually be found in a blend of these two extremes, a client might tend to favor a balance decidedly tipped toward having his or her own worldview valued and understood. Seen from a client's perspective then, there is little question about whether psychotherapy should be made congruent with cultural contexts. By incorporating macro-level cultural worldviews, therapists match the perspective of individuals who share that worldview.

Nevertheless, because researchers and therapists tend to make decisions based on reasons other than client preferences, some additional rationale for changes in mental health interventions may warrant consideration. As a fiscal consideration, culturally congruent mental health practices affect client utilization and retention. The number of mental health providers across the world has increased markedly over the past four decades, growth which is directly proportional to the willingness of the population to pay for psychotherapy (either directly or indirectly through insurance premiums or public funding). Yet people of color tend to underutilize mental health services compared to people of European origin (U.S. Department of Health & Human Services, 2001). Research has demonstrated that clients of color are more likely to seek out and remain in therapy when interventions are congruent with their personal values and beliefs (Coleman, Wampold, & Casali, 1995; Flaskerud & Nyamanthi, 2000). If therapists would integrate clients' cultural perspectives into treatment, then utilization and retention rates

for people of non-European origin would likely increase over time (Hall, 2001), further enhancing growth of mental health services worldwide.

Culturally congruent practices have also been shown to enhance client outcomes in psychotherapy. Race and culture moderate how mental health symptoms are interpreted and expressed (e.g., Atkinson et al., 2001; Varela et al., 2004). Racial and cultural groups have similar yet distinct perspectives about well-being. People of color often fear that their particular beliefs/worldviews will be misunderstood by mental health professionals (e.g., Cinnirella & Loewenthal, 1999; Whaley, 2001). Multicultural competency in treatment has the potential to augment the effectiveness of that treatment by such factors as strengthening the therapeutic alliance and drawing upon existing client resources (e.g., Vasquez, 2007).

Considering concepts and ideas across cultures can benefit therapists' own conceptualization of well-being and treatment. Practices and traditions of cultures across the world have effectively enhanced coping, resilience, and healing (e.g., Garrett, 1999). Such traditions and insights can make valuable contributions to contemporary therapeutic practices, which historically have been based exclusively on European and North American healing traditions (e.g., Katz, 1985; D. W. Sue & D. Sue, 2008). For example, the recently popular "mindfulness-based cognitive therapy" and "acceptance and commitment therapy" are based on Buddhist teachings (e.g., Hayes, Follette, & Linehan, 2004). Researchers are increasingly recognizing the wisdom in traditional cultural and religious practices and values that for generations have enhanced mental health and prevented mental illness in other areas of the world (Koenig, McCullough, & Larson, 2001; Richards & Bergin, 2000).

Pragmatic observation also supports multiculturalism as essential to effective practice. Because each human is in many ways unique, no single approach or technique will work with every person or group (Smith, 2004). This problem of generalizability has yet to be adequately addressed in mental health research (Sue, 1999). In our theories and training we attempt to generalize from one client to the next, but in the real world, treating all clients alike ensures incompetence. If differentiation across clients is essential, it makes sense to understand and apply the prime factors that account for client differences (i.e., age, gender, race, socioeconomic background, etc.).

Finally, ethically and even morally the "best practice" is to incorporate cultural values and symbols when working with people for whom those values have meaning (Arredondo & Toporek, 2004; James & Foster, 2006; Smith, Richards, Granley, & Obiakor, 2004). Making practices congruent with the characteristics and needs of those who seek mental health assessment or treatment is a professional responsibility. Ethical standards of the American Psychological Association (APA, 2002) and American Counseling Association (ACA, 2005) include cultural considerations, and these organizations have provided specific guidelines relevant to multicultural considerations (APA, 2003).

Given these benefits, culturally congruent practices seem not only viable but integral to effective mental health services. Nevertheless, such arguments have been made for decades (i.e., Sue & Zane, 1987). Despite the continuous publication of logical arguments like these and the continuous publication of hundreds of observations regarding the benefits of culturally congruent practices by clinicians working with clients of color, contemporary mental health practices differ little from those of 30 years ago,

well prior to the recent "multicultural revolution" (Sue, Bingham, Porché-Burke, & Vasquez, 1999). Although practitioners have increasingly become aware of the need for multicultural competence through repeated calls in the literature (e.g., Hall, 1997), the implementation of culturally congruent practices lags well behind this general awareness (Constantine & Sue, 2006, 2005; D. W. Sue & D. Sue, 2008).

Given this discrepancy, it may be useful to consider a historical parallel to the contemporary acceptance/application of multicultural counseling and psychotherapy. Although now largely forgotten, for many decades doubts were expressed about the efficacy of psychotherapy itself (i.e., Eysenck, 1952, 1993). Under scrutiny, psychotherapists were sometimes defensive, citing logical arguments and generating hundreds of case studies to prove their position. Psychotherapists believed in their own work, but they generally lacked respect within the larger community. It was not until the first major synthesis of empirical data (Smith & Glass, 1977) conclusively demonstrated the efficacy of psychotherapy that the whole terms of the debate changed. The question of efficacy had been answered conclusively: Psychotherapy works. The focus of scholarship turned to nuances of effectiveness (e.g., psychotherapy with specific conditions, with specific components, with specific intensity/duration, etc.). Meta-analytic data had provided the field with legitimacy and with the associated confidence to promote mental health services among insurance providers, federal and state legislators, and the general public.

Perceptions of counseling and psychotherapy 40 years ago parallel some views of culturally congruent practices within the mental health professions today. The idea receives general support, but limited implementation in practice. Claims by advocates of

culturally congruent practices are politely acknowledged but not always applied within the larger profession, let alone local clinics. Given the historical precedent for empirical data to provide confidence sufficient to radically change perceptions and practices, this chapter will shift focus from logical rationale to empirical evidence.

Empirical Evaluations of Culturally Congruent Mental Health Practices

Systematic methods for reviewing empirical research, called meta-analyses, have greatly improved the confidence of the mental health field in identifying overall trends across numerous research studies (Cooper, 1998; Labin, 2008). Because they are systematic, comprehensive, and replicable, meta-analyses have replaced the need for conducting narrative literature reviews; the results of a meta-analysis provide the most reliable summary of the literature.

A meta-analysis of culturally congruent mental health interventions. In 2006, a meta-analysis of 76 studies demonstrated the effectiveness of culturally congruent mental health interventions (Griner & Smith). Across a wide variety of studies, interventions that intentionally included cultural considerations (e.g., Africentric interventions for African Americans, *Cuento* therapy for Latino youth) were more beneficial to clients than those that did not (Cohen's $d = .45$ or a difference of about one half of a standard deviation). This finding maintained across a variety of circumstances and participant characteristics: For example, studies with participants of different gender, race/ethnicity, and level of distress all yielded equivalent average effect sizes. Thus the benefits of culturally congruent interventions appeared to generalize across many circumstances.

Additional findings of the meta-analysis included several factors that likely moderated the effectiveness of culturally congruent interventions. Key among these were

three variables related to the salience of culture from the perspective of the client. First, a statistically significant correlation ($r = .29$) between the average age of participants and the effect size from each study indicated that adults tended to benefit more from culturally congruent interventions than did children and adolescents. This finding is presumably due to differences in the salience of culture (enculturation) across age groups, with adults typically identifying with cultural values more than children or adolescents (e.g., Kwak, 2003). Second, interventions in which clients had access to services delivered in their preferred language (i.e., bilingual therapists) were much more helpful for clients ($d = .49$) than services apparently conducted exclusively in English with clients who were apparently not native English speakers ($d = .21$). Third, interventions that were specific to a particular racial/ethnic group were more effective ($d = .49$) than interventions delivered to a mixed group of participants from different races/ethnicities ($d = .12$). Thus interventions apparently tailored to meet the needs of a specific group were more effective than those in which interventions included general multicultural considerations. The common theme across these three findings is that the more congruent an intervention was with clients' cultural worldviews, the more effective it was in helping them.

Although enhanced client satisfaction with services was the outcome variable most impacted by culturally congruent interventions ($d = .93$), client retention also improved to some degree ($d = .30$). Across studies that evaluated reductions in client mental health symptoms, the average improvement relative to control groups was $d = .39$ (a little more than one third of a standard deviation of difference). Taken as a whole, the results of the meta-analysis provided a wake-up call to the profession. Data now support

what scholars investigating culturally congruent interventions had been emphasizing for decades (e.g., S. Sue & Zane, 1987).

Additional considerations about the meta-analytic data. Meta-analyses have multiple advantages over traditional literature reviews (Cooper, 1998; Labin, 2008). However, meta-analyses are also subject to several criticisms, including mixing articles with similar yet distinct research methodologies, outcome variables, etc. (e.g., Eysenck, 1993). Although these concerns apply generally to all meta-analyses, these specific concerns could also be leveled at the meta-analysis just described (Griner & Smith, 2006). One might ask whether the results of that meta-analysis would have been different if (1) studies including any European American participants had been excluded, (2) studies utilizing only experimental designs had been examined, and (3) studies investigating only mental health interventions with clinical populations had been included. These and related questions will be addressed through analyses conducted with the data collected by Griner and Smith that were not reported in the original publication.

Of the studies reviewed in the meta-analysis, 10 included European Americans as part of the sample (either as a comparison group or as a small percentage of those receiving the intervention). Excluding those 10 studies resulted in an overall effect size of $d = .48$ (95% CI = .39 to .57), virtually the same as the originally reported value of $d = .45$ (95% CI = .36 to .53). Moreover, after subsequent analyses of the variables found to moderate the overall results (i.e., age, language of services, culture-specific services) results remained unchanged. Thus the original findings of the meta-analysis could not be attributed merely to the presence of some European American participants in studies with participants from a variety of racial backgrounds.

Many of the studies reviewed in the meta-analysis involved comparison groups without an equivalent control group, and some of them involved pre- to post-test changes with a single group. Given the multiple limitations associated with those research designs, a subsequent analysis with the data from only the 48 studies using experimental designs yielded an overall effect size of only slightly lower magnitude (d = .39, 95% CI = .29 - .48) than findings across all 76 studies. Additional analyses of the moderating variables also replicated the results obtained with the full 76 studies. Thus these analyses confirm the overall findings of the meta-analysis as published.

Lastly, because the meta-analysis reviewed a wide variety of intervention studies that considered (1) preventative mental health (i.e., social skills training for at-risk youth) and (2) substance abuse treatment/prevention, as well as (3) psychotherapy and related mental health interventions (i.e., family therapy), it would be important to distinguish the findings accordingly. Nevertheless, the average effect sizes were equivalent across these three different types of services (d = .36, .45, and .46, respectively, $p > .10$), with psychotherapy-type interventions being more effective than the other two types of interventions. These findings again confirmed the original published results: Mental health interventions that are culturally congruent with clients of color are much more effective than services provided without such considerations.

Data interpretation. The data of the meta-analysis by Griner and Smith (2006) are open for interpretation. These analyses are based on relatively few research reports: 76 studies, in contrast to the 375 studies involved in the original meta-analysis of psychotherapy effectiveness conducted by Smith and Glass in 1977. Moreover, dozens of meta-analyses involving hundreds of additional efficacy studies on traditional

psychotherapy have been conducted since 1977. Thus even with the substantive findings of the single meta-analysis of culturally congruent practices (Griner & Smith), it may require additional evidence (possibly dozens of efficacy studies using rigorous designs and controls) before the entire profession becomes completely convinced of the need to completely infuse cultural considerations into traditional practices.

Similarly, a skeptic of multiculturalism might consider the differences observed between practices that are and are not culturally congruent to be only moderate in magnitude (as per guidelines provided by Cohen, 1987). However, the differences observed in the data (Griner & Smith, 2006) are of the same magnitude observed when comparing psychotherapy with a licensed psychologist to a placebo treatment, such as a social support group run by a trained undergraduate (Lambert, 2005). To put this comparison into perspective, if an effect of this magnitude ($d = .45$) were consistently found between one type of mental health treatment and another (e.g., humanistic vs. cognitive-behavioral therapy or one psychopharmacological agent vs. another), the less effective treatment would no longer be considered empirically justified. Therefore, so long as the meta-analytic data prove replicable, every mental health intervention should be made culturally congruent.

Implementation of Culturally Congruent Practices

All other things being equal, empirical evidence should guide infusion of culturally congruent practices throughout counseling and psychology. If so, then direction is clear: Culture is of primary, not secondary, import.

Given the demonstrated relevance of cultural issues, traditional mental health interventions or those designed without explicit cultural congruence for people not

already aligned with European/European American worldviews will benefit from revision. Even when traditional interventions appear to be effective with clients of color (Miranda et al., 2005), deliberate inclusion of cultural considerations will likely enhance their effectiveness. Moreover, non-traditional interventions designed to meet the needs of specific populations are now accepted. In any case, these two approaches, refinement of traditional interventions and promulgation of new interventions grounded in clients' cultures, will both benefit from utilizing conceptual frameworks for culturally congruent practice (Castro, Barrera, & Martinez, 2004).

Conceptual guidelines. How should culturally congruent practices be designed and implemented? At the most fundamental level, such practices should be congruent with the client's cultural values, conceptualization of change, and expectations regarding normative behavior (S. Sue, 1988). When mental health interventions include multicultural considerations yet fail to account for these foundational principles, the role of culture remains superficial, distanced from client experience (see related concepts of ecological and social validity; Bernal, Bonilla, & Bellido, 1995). Although traditional therapy can be improved by adding culturally relevant components, such as utilizing the *Kaffa* ceremony with Ethiopian refugees (Loewy, Williams, & Keleta, 2002), optimally such integration of cultural variables occurs across the entire treatment. Thus *the optimal focus of culturally congruent practice is alignment with client experiences*, rather than the specific cultural components used to facilitate that alignment.

Recognizing the risks of nominal or unsystematic inclusion of cultural considerations in therapy, several authors have provided conceptual frameworks to aid therapists in implementing practices that are truly culturally congruent. For example,

Castro, Barrera, and Martinez (2004) indicate that culturally congruent practices should not only involve patently compatible cultural concepts but also attend to cognitive, affective-motivational, and environmental factors. Moreover, such practices should go beyond content to include form: channel of delivery (e.g., group/family rather than individual), location of delivery (e.g., community center/church, rather than clinic), and qualities of the therapist (Castro et al.). In short, there are a variety of ways in which cultural mismatches can continue despite nominal attention to clients' cultural backgrounds.

Guillermo Bernal and colleagues (Bernal & Saez-Santiago, 2006; Bernal et al., 1995) have generated useful guidelines for professionals attempting to provide culturally congruent practices. Their framework includes eight dimensions:

(a) Language (Conduct therapy in the preferred language of the client.)

(b) Persons (Match client-therapist on salient variables to enhance the therapeutic alliance and client expectations.)

(c) Metaphors (Use expressions, objects, and concepts already embedded within the client's culture.)

(d) Content (Apply cultural knowledge about values, customs, and traditions.)

(e) Concepts (Conceptualize the presenting problem consistent with clients' cultural worldviews.)

(f) Goals (Identify clients' desired outcomes.)

(g) Methods (Use procedures in treatment that align with clients' cultural worldview and goals.)

(h) Context (Consider the social, economic, and political realities that impact the client.)

These eight elements should inform the development of culturally congruent practices and can be utilized in the future to evaluate the quality (i.e., ecological and social validity) of interventions described in the literature. For example, Domenech-Rodriguez and Wieling (2005) have demonstrated a useful application of these eight elements when developing a systematic procedure for working with Latino/a parents and their children. Systematic demonstrations such as these will go a long way toward improving the quality of culturally congruent practices.

At present, the field could benefit from increased systematization in implementing these guidelines (Bernal & Saez-Santiago, 2006; Bernal et al., 1995). A review of the literature demonstrates that adherence to these guidelines is highly variable: About one half of the elements (an average of 3.8 out of 8) characterize studies that attempt to promote culturally congruent practice (as identified through post hoc analyses of studies identified by Griner and Smith, 2006). The practices described within studies typically include some but not all of the eight elements: 84% provided therapy in the clients' preferred language, 61% matched clients with therapists of similar ethnic/racial backgrounds, 29% utilized metaphors/objects from client cultures, 84% included explicit mention of cultural content/values, 21% adhered to the client's conceptualization of the presenting problem, 11% solicited outcome goals from the client, 44% modified the methods of delivering therapy based on cultural considerations, and 49% addressed clients' contexts by either providing external services (24%) or discussing contextual issues (33%). These findings prompt greater attention to the elements that are relatively

deficient in current efforts to implement culturally congruent practices (i.e., metaphors, concepts, goals, and methods). Given the inconsistent adherence to best practices in studies presently available in the literature, it is likely that future multi-faceted practices following all eight guidelines may result in greater therapeutic benefits than those observed in the meta-analysis of prior research findings (Griner & Smith).

Why are culturally congruent interventions more effective than traditional interventions? The conceptual guidelines suggested by Bernal and colleagues (1995) are based on sound reasoning, years of clinical practice, and research findings from related fields of inquiry. However, the conceptual models are broad, accounting for a multiplicity of salient factors. They articulate key considerations but do not specify underlying causal mechanisms. Until causal mechanisms are specified, conceptual guidelines will necessarily remain comprehensive, broad enough to capture the associated complexity.

It may therefore prove useful to consider possible reasons *why* culturally congruent practices might improve client outcomes. Identifying such factors may help focus future research efforts and could result in refined conceptual models that lead to more widespread implementation of culturally congruent practices.

One hypothesis worth testing is that several underlying (indirect) factors may better account for the efficacy of culturally congruent mental health practices than the (direct) practices themselves. The inclusion of cultural components in therapy (e.g., sharing folk stories or cultural maxims) is likely not the sole reason why clients improve. Improvements observed in clients may be largely due to more general factors. Atkinson, Bui, and Mori (2001) articulated three generic reasons relevant to client/therapy

matching: compatibility of racial/ethnic identity, beliefs about the causes of problems, and beliefs about which treatments are effective for those problems. The logic is that if client and therapist complement one another on these factors, the therapy provided will be more efficacious than otherwise.

The fact that the data from the meta-analysis (Griner & Smith, 2006) failed to ascertain differences across several intervention components (e.g., content, method, modality, duration) supports the hypothesis that general factors, rather than treatment-specific factors, explain the enhanced effectiveness of culturally congruent practices compared to traditional practices. The specific type of intervention provided may matter much less than the fact that the intervention remains congruent with clients' experiences and worldviews.

The parallel concept advocated in the psychotherapy literature has been termed the *common factors* approach (see Frank, 1982; Rosenweig, 1936). From this perspective, no single approach or theoretical orientation works better than any other; rather, the efficacy of any treatment depends on how it well it promotes the client-therapist relationship, client expectations for improvement, etc. (e.g., Wampold, 2001). Any form of psychotherapy works—to the extent it provides these common factors.

By this logic, culturally congruent practices align well with common factors (Atkinson et al., 2001). It is not the act of allowing a client to pray in session or pour libations in honor of deceased ancestors that reduces the client's symptoms; rather, it is the fact that such acts have multiple indirect effects, which include implicitly honoring the client by honoring his or her family members, referring to external resources and role models, drawing upon spiritual resources, and enhancing the level of intimacy in the

client-therapist relationship. Examples of indirect effects broken down by three common factors are provided in Table 1. Multiple indirect effects, such as those listed in the table, have great power collectively. Therefore, a hypothesis worth evaluating in future research concerns the summative effects of culturally congruent practices: Even one culturally congruent component in treatment should be better than omission of cultural considerations, but the most efficacious interventions should be those which result in multiple indirect effects.

Informed interventions vs. misuse. If culturally congruent practices are to become the norm in the profession, then a danger posed by this proliferation concerns the possible misuse of those practices, such as by misapplication (e.g., improper timing or mismatch with client expectations) or by misappropriation (i.e., cultural thievery, which is using precepts from indigenous cultures for personal gain or without consent of or collaboration with acknowledged representatives of the host culture). Competence in traditional schools of psychotherapy (e.g., Adlerian, Interpersonal, Reality Therapy, etc.) requires extensive supervision and practice. How could a therapist possibly become competent in culturally congruent practices without similar supervision and skill refinement? (Ladany, Friedlander, & Nelson, 2005). Well intentioned therapists may integrate relevant cultural concepts (e.g., acceptance of fate as a way to enhance inner peace and thus decrease symptoms of depression) that may actually harm clients under some circumstances (i.e., fatalism without the larger cultural concept of unity/oneness could prompt thoughts of suicide). Similarly, therapists must attend to within-group heterogeneity (Zane, Hall, Sue, Young, & Nunez, 2004), such that the inclusion of a cultural practice does not perpetuate a different set of assumptions/stereotypes when working with individuals who

may differ widely from cultural norms. In short, interventions are merely tools that can be used to promote or detract from well-being. The focus of therapy should remain on the client and his/her context, with interventions matching accordingly. Hence, the emphasis that this chapter has placed on culturally congruent practices must be matched by a larger professional emphasis upon ethics, training, and ongoing professional development.

Conclusion

For many years scholars have affirmed that culturally congruent practices are more effective than traditional practices with ethnic minority clients (e.g., Hall, 1997; Sue, 2003; Zane, Hall et al., 2004). They were right. Culturally congruent practices are more effective than practices that do not account for clients' cultural contexts.

Thus culture should be a primary, not secondary, consideration in the development and implementation of mental health interventions with clients who do not align with European American worldviews. However, it must be emphasized that this perspective, merging individual-level and macro-level conceptualizations, does not denote contradiction. It is not an either/or scenario. Individual-level factors will always be a focus of psychotherapy, and those individual factors are better understood when simultaneously accounting for larger contexts. Thus multiculturalism is not merely a macro-level abstraction, but a necessary overlay to understand each individual client.

Historically, counseling and psychotherapy practices have undergone constant revision. To wit, we rarely see clients five times per week, and we utilize methods not wholly dependent upon Freud, Skinner, or Rogers. Change is constant in the profession, and the need to develop, evaluate, and maintain culturally congruent mental health

practices should impel improvement. Based on the principles of multicultural competence (e.g., Arredondo & Toporek, 2004; Constantine & Sue, 2005, 2006) psychotherapy can better meet the needs of clients whose worldviews are not presently represented by traditional paradigms. Irrespective of differences that may emerge across the content and method of culturally congruent practices, the essential features will be accessibility, interpersonal connectivity, worldview congruity, and utility (usefulness). How we have been trained as counselors and psychotherapists may not be what our clients may need. What do they need? How can we respond?

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Table 1

Common Factors and Associated Indirect Effects that May Account for the Effectiveness of Culturally Congruent Mental Health Practices

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Client/Therapist Mutual Understanding

Implicit interpersonal valuing (affirmation)

Implicit structure/frame for the encounter (familiarization)

Attention to interpersonal similarities (cohesion)

Validation (normalization)

Enhanced communication fluidity and accuracy

Client/Therapist Mutual Responsiveness

Reduced interpersonal anxiety (enhanced trust)

Improved expectations for outcome (hopefulness)

Willingness to engage (personal investment)

Pledges/commitments with one another (co-created bonds)

Acknowledged interdependence (equality)

Demonstration of appropriate social skills (in vivo modeling)

Mutually Satisfactory Therapeutic Actions

Recognition and reinforcement of client strengths and coping methods

Rehearsal of realistic alternatives for coping

Involvement of client support networks (connectivity and accountability)

Communal reintegration (forgiveness/reconciliation)

Symbolic healing (ritual/ceremony/imagery)

Spiritual perspectives; invitations for intervention from spiritual sources

Plans for/acceptance of an unknown future

Description of compatible examples to emulate

Acknowledgement of cultural values/principles that may guide decisions/actions

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Note: The three categories above generally correspond with the common notions of therapeutic alliance (broken down into understanding/responsiveness) and therapeutic interventions. The terms are purposefully altered to denote the reciprocal influence of client and therapist.