CHAPTER 11

CULTURAL COMPETENCY

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INTRODUCTION

A strong, yet unnoticed undercurrent exists today in the United States. This undercurrent is nearly pervasive, affecting most of behavior, variations in thinking, and guiding people in their actions and interactions. For centuries, this underlying phenomenon has influenced our society and professions without being explicitly acknowledged and addressed, until recently. Due to the ever-increasing diversity in America, culture and multiculturalism have begun to be of focus in research and healthcare. However, this focus is not yet strong enough to have the necessary impact to create a society where all are equally healthy or have equal opportunity to succeed. Culture is a multidimensional and potent construct that influences health behaviors, ways of thinking, beliefs and values, language, relationships and relating, among many other human dynamics. Because of its omnipresence, it is often forgotten or ignored. Further, due to ethnocentrism and the human propensity to favor those in-group or similar, multiculturalism is also devalued or unnoticed. This natural tendency is further complicated in helping professions and interdisciplinary teams—when there are also multiple cultural influences (values, beliefs, history) on various levels (individual, interpersonal, teams). Those who are trying to help change behavior and enhance health necessarily must meet and face these challenges. Since improving health and society is most effective through sound interdisciplinary teamwork (Langer, 1999; Purden, 2005; Bell, McBride, Redd, & Suggs, 2012), the interdisciplinary team must travel on the path toward cultural competence. This chapter explicates the need for cultural competence, the process of enhancing cultural competence, cultural competence in interdisciplinary teams or "interprofessional cultural competence" (Pecukonis, Doyle, & Bliss, 2008), and assessing cultural competence.

STEREOTYPING AND CONSEQUENT BEHAVIORS: EVERYONE DOES IT

Cultural competence is a construct that many may deem either unnecessary or irrelevant due to color-blindness (Burkard & Knox, 2004) or a denial of prejudice (Alexandar, 2010; Greenwald & Banaji, 1995). With the passing of the Civil Rights Act of 1964 and the years following, people of the United States find it difficult to admit to any prejudice, discrimination, or tendency to stereotype. However, prejudice, discrimination, and stereotyping are natural human mechanisms (Pinderhughes, 1979; Greenwald & Banaji, 1995; Pecukonis, Doyle, & Bliss, 2008; Fiske, 1992) that have protective and psychological value. Due to automaticity (i.e., the natural tendency of the brain to conserve energy and automate processes and behavior), we create associations and stereotype. Ofttimes, these associations and stereotypes are constructive (Fiske, 1992). For example, even if a chair is a different shape or color than we are used to, we know we can sit in it and not have to use mental energy figuring out if it is something upon which we can sit. Our energy is saved for something more significant, like danger and protection. This function can be used not only to preserve energy but also to cope with uncertainty, especially in social situations. According to Pecukonis, Doyle, and Bliss (2008),

> Reducing this subjective sense of uncertainty within our important social interactions promotes predictability and control. One way to reduce uncertainty is to utilize stereotypes.... These biased, but easily available templates or prototypes provide a roadmap for behavior within these social situations, and thus reduce uncertainty (p. 422).

However, like many human phenomena, these psychological protective mechanisms can become exaggerated and maladaptive. When unnecessarily transposed onto people or groups, gratuitous fear and divisions can ensue, which work against social protective factors, like collective efficacy or community. In short, certain stereotypes incite prejudice and discrimination (American Psychiatric Association, 2006). These attitudes and behaviors often work below the surface of consciousness (i.e., "implicit cognition") and are affected by experiences and exposure. Stereotyping and attitudes have "implicit modes of operation," which means that even if a person explicitly denies adopting a certain stereotype or prejudice, a feeling or belief may still very well be operating and driving behaviors but on an subconscious level (Greenwald & Banaji, 1995). Therefore, we must be aware of the presence of underlying stereotypes and prejudice despite believing we may be color-blind or see everyone neutrally. Furthermore, *any judgment placed upon implicit processes needs to be ameliorated*, especially in order to recognize, identify, and address them.

THE HARM OF CULTURAL INCOMPETENCE

Due to this implicitness and the influence of implicit cognition on behavior, myriad unintentional slights occur toward marginalized groups (e.g., people of color, low socioeconomic status (SES) communities, disabled, and women). These slights are called microinsults and *microaggressions* (Pierce, 1995; American Psychiatric Association, 2003; Sue et al., 2007), a form of

cultural incompetence. An example of a microaggression is if a customer in a grocery store mistakes a black man for a store employee, when in actuality he is another customer. Another example is a woman in a healthcare setting who is presumed to be a nurse when she is a physician. Microaggressions have been identified as contributing to current racial disparities in this nation, including education (Gordon & Johnson, 2003), health (Betancourt, Green, Emmilio, Carrillo, & Park, 2005; Gilmore, 2007; Langer, 1999), and equal opportunities for employment (Alexandar, 2010; Gordon & Johnson, 2003). These offenses can take many forms, including ignoring a group's history (e.g., oppression) and/or context (e.g., structural barriers to success for people of color) and being condescending to a person or group (Sue et al., 2007). In the criminal justice system, these slights are demonstrated through a disproportionate focus of police officers on young black men. This focus has led to significant and devastating racial disparities in the criminal justice system and the creation (or perpetuation) of a "racial undercaste" (Alexandar, 2010).

In health care, these insults can manifest in the doctor–patient relationship. The doctor may ignore contextual struggles of a person from a low SES community that hinder compliance to a medical regimen and, therefore, label the person "noncompliant." Van Ryn and Burke (2000) found that race affects physicians' perceptions of patients. Despite controlling for SES and education, Black patients were perceived as more likely to abuse alcohol and substances, less likely to comply, less likely to accept or go along with recommendations or prescriptions, less intelligent and educated (despite being educated), and black patients from low SES communities were less likely to be seen as pleasant or rational. (Remember: Implicit cognition affects behavior [Greenwald & Banaji, 1995].) Subsequently, the Agency for Health Care and Research Quality (AHCRQ, 2006) conducted a study examining the variation in relationships that patients of different ethnicities had with their healthcare providers. The findings are not surprising, given the aforementioned differences in implicit cognitions of physicians. African Americans, Asian American/Pacific Islanders, and Hispanics reported they were not listened to carefully, were not given proper explanations, or were denied respect more often than their European American counterparts. Further, Asian Americans/Pacific Islanders, African Americans, Native Americans, and Hispanics reported sometimes or never having good communication with healthcare professionals more often than their white counterparts. All this exists despite research supporting the patient–doctor relationship influences the patient's health status and outcomes (AHCRQ, 2006). This type of negligence or incompetence can also affect prescriptions and effectiveness of medication (Herbeck et al., 2004). For example, because of biological variation between ethnic groups (e.g., ability to metabolize CYP 2D6 substrates: Lin, Smith, & Ortiz, 2001), different ethnic groups have different levels of tolerance for psychiatric medications (Lin & Elwyn, 2004). Therefore, the general doses doctors may prescribe to the American majority—Caucasians—may not be healthy for the American minority—people of color (Bell, 2008). We must realize and acknowledge that Western medicine is not a panacea, nor is it always "best practices" (Katz, 1985). The efficacy of any treatment, even so-called evidence-based, can depend on cultural and contextual variations (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996). Thus, for a clinician to disregard or ignore culture and context is irresponsible and goes against the Hippocratic Oath and healthcare ethics of non-maleficence and beneficence.

This lack of consideration has also been present in the relationships of mental health professionals and their clients (Thomas & Sillen, 1972). Burkard and Knox (2004) found that professionals who hold color-blind racial attitudes are likely to avoid attributing a person of color's

plight to racist institutions or history. Instead, they attributed it solely to "laziness" or lack of effort, thus, perpetuating racism and increasing the chances of that person not completing therapy. Those indicating higher color-blindness exhibited statistically significantly less empathy and placed the responsibility of solving the problem on the black clients more often than on the white clients, which has led to premature termination, amplifying the extant distrust of psychiatric services in people of color (Wade & Bernstein, 1991).

DEFINING CULTURAL COMPETENCE

Ostensibly, cultural incompetence has deleterious effects on health and society. Therefore, building cultural competence within health professions and society in general is vital and necessary to achieving social justice on all fronts.

The root of cultural competence is culture. Various definitions have been used for *culture*. The American Psychological Association (2003) has a comprehensive definition. Therefore, we have adopted their definition, which is:

> the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, caretaking practices, media, educational systems) and organizations . . . [and] the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions. It also encompasses a way of living informed by the historical, economic, ecological, and political forces on a group (p. 380).

Culture can be seen as many things; however, there are constructs that culture is often confused with, like race. Although race is related to culture, they are not synonymous (U.S. Department of Health and Human Services, 2001). Their relationship is through context. Due to the shared contextual and/or historical experience of many racial groups (e.g., slavery, internment campus oppression), the people within those groups *generally* have adopted similar beliefs and values. The term *generally* is emphasized here because all groups have more variation within the group than between (Rogoff, 2003; McBride, 2011). Thus, it is important, when moving toward cultural competence, that people do not adopt new stereotypes based on the information learned in the process.

Cultural competence is knowing this fact, balancing it with culture and shared experience and values of groups, and recognizing and responding to the aforementioned implicit cognitions and microaggressions. Furthermore, cultural competence is: 1) the awareness of one's own biases and attitudes, cultural influences, behaviors, and communication style, and how they differ from others'; 2) the knowledge of one's own cultural influences and the cultures of others, how cultures have developed over time and are shaped by context, how current macro- and micro-structures can affect the individual or a group; 3) the skills in responding to differences in culture and communication and addressing macro- and micro-structures that perpetuate social injustice (Sue, 2001; Sue, Arredondo, & McDavis, 1992). Cultural competence is also seen as compassion, empathy, listening, and understanding. Since culture can be applied to various groups, including organizations, disciplines, and professions, cultural competence also applies to interdisciplinary work (Fanchet, 1995). Pecukonis, Doyle, and Bliss (2008) call this

"interprofessional cultural competence." Overall, the purpose of cultural competence is to interact with and effectively respond to people of different backgrounds and belief systems, abate extant disparities, and ameliorate social injustice still present in organizations and society.

THE IMPORTANCE OF CULTURAL COMPETENCE

Cultural competence has been found effective in addressing these problems, especially around mental, behavioral, and physical health, which is the focus of this section. Wade and Bernstein (1991) found that when black female clients were randomly assigned to counselors with and without cultural competence training, the clients with the culturally competent counselors fared better in therapy. They attended more sessions, completed therapy, and were more satisfied with their treatment than those who had received therapy from a counselor without cultural competence training. A similar effect has been found in HIV prevention. Responding to and incorporating the culture of the participants has been effective in changing behavior. Kalichman et al. (1993) showed three videos discussing HIV/AIDS to African American women, with the goal of reducing risky behaviors. One video showed Caucasians talking about the epidemic and how to protect oneself; another video showed black women giving the same information in the same context; and the final video showed black women giving the information, but in a community setting with culturally relevant context (e.g., community, family). The culturally relevant video was the most effective. Significantly more women who viewed this video were tested for HIV following the viewing and came to receive condoms at follow-up; they were also more concerned about the epidemic. Using culturally relevant messages and communication has also been effective in preventing substance abuse. The Strong African American Families program (Brody et al., 2004) found inclusion of racial socialization to be effective in preventing substance abuse with black adolescents. For one of the most fatal diseases plaguing African Americans, culture was found, again, to be an integral factor in effective prevention. Paz (2002) asserted the same—culturally competent substance abuse prevention works—with Latinos. Stolley, Fitzgibbon, Wells, and Martinovich's (2004) intervention incorporated issues such as "soul food" and gave recipes and training on making healthy soul food; information on low-cost, easily accessible healthy behaviors (e.g., exercise tapes at homes, walking); addressed family and their behaviors; and integrated religion/spirituality in their teaching of healthy living. The culturally specific intervention worked well and was much appreciated by the participants. Bell et al. (2008) illustrate how adapting a U.S.-based HIV prevention intervention to a South African Zulu culture increases acceptance of the intervention. Zeller (2008) described a program integrating Aboriginal culture for Aboriginal men in prison for battering. The program infused cultural beliefs (spiritual, medicine wheel), values (peace, good relationships), rituals (corners of the earth/directions), and practices (sweat lodge) in rectifying behavior. The use of culture was effective in increasing openness to others, enhancing social skills, and improving communication.

Within medical care, the lack of cultural competence can lead to prolonged morbidity and premature mortality, for if patients do not comply with (competent) suggested medical regimens, they may die. Therefore, developing a solid working alliance is essential to positive health outcomes; cultural competence and sensitivity is integral in developing this quality relationship. Further, true understanding of a patient's predicament and ability to apply recommended

behaviors depends on the level of cultural competence and openness of the doctor (Langer, 1999). Diabetes is one example of the necessity for cultural understanding. This is a lifelong disease that is greatly affected by health behaviors, and culture influences behavior that can affect health. The health professional should be knowledgeable about the culture(s) and the related behaviors in order to make accurate assessments and provide good recommendations or responses (Langer, 1999; Tang, Fantone, Bozynski, & Adams, 2002). Understanding these influences will also help the professional in understanding why adherence did not occur. Examples of some of the barriers to health behavior related to context/culture are poverty, overcrowded housing, neighborhood crime (inhibiting exercise), diet, and a lack of transportation (Langer, 1999).

As with health problems like diabetes and substance abuse, both general and interprofessional cultural competence are integral in optimal care, especially since such disorders require addressing both the mind and the body (Langer, 1999). Therefore, interdisciplinary team functioning can directly affect patient care. Purden (2005) found, in Canada with the Aboriginal people, effective health services are respectful and understanding of the culture, include the community, and use an interprofessional or interdisciplinary approach in order to bridge the gap in health services in certain areas. If the various professionals cannot effectively relate and communicate, the common mission is compromised. Cultural competence in this arena, like all others, encompasses openness, self-exploration (Richardson & Molinaro, 1996), listening, and understanding (Langer, 1999).

THE PROCESS OF CULTURAL COMPETENCE

Cultural competence is a process of becoming that can be adopted on multiple levels, from the micro to the macro (see Figure 11.1). Sue (2001) described a comprehensive model for cultural competence called the "multidimensional model for cultural competence," which includes: 1) dimensions—race/ethnicity/culture specific (e.g., Black, Native, Hispanic, Asian, and White); 2) components of cultural competence—self awareness, knowledge, skills; and 3) foci—individual,

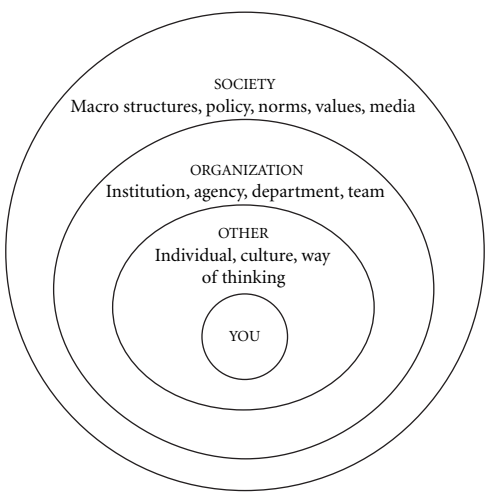

FIGURE 11.1 Levels of Cultural Competence

professional, organizational, societal. It can be manifested within the individual in thought, attitude, and action, within the organization in policy, practice, and philosophy, and within society through social equity and competent policy. In Figure 11.1, the you represents each one of us—both our internal processes and dynamics and overt behaviors. The other represents other individuals that we can influence (e.g., our colleagues, friends). Organizations represent structured entities comprised of people, policies, and institutions. Lastly, society is the larger social structure, including people, communities, norms, and greater policies.

INDIVIDUAL/OTHER/PROFESSIONAL

This process begins with the individual, starting with the three components: awareness of beliefs and attitudes, knowledge, and skills (Sue, 2001; Sue, Arredondo, & McDavis, 1992). Becoming aware of and acknowledging one's implicit and explicit beliefs and attitudes involves introspection. This aspect encompasses a growing awareness of biases and how they influence psychological processes and relationships with clients/treatment. It means being sensitive to one's own cultural influences and biases, recognizing one's limits, and being aware of cultural differences between oneself and others (clients) and emotional reactions toward clients of other cultures, races, and ethnicities (Richardson & Molinaro, 1996; Sue, Arredondo, & McDavis, 1992).

The aspect of knowledge includes knowledge of one's own cultural influences, personal and professional, and how they impact decisions, definitions, and biases of abnormality and normality (Reich & Reich, 2006; U.S. Department of Health and Human Services, 2001). What are various aspects of American culture? How do these cultural influences (e.g., individualism, capitalism, materialism) affect living for different individuals and groups in society? For instance, American culture is highly individualistic. This dynamic can create problems not only for those who grew up and adopted the culture but also for those outside of the culture or who have other stronger cultural influences (e.g., Asian American, African). This individualism can work against true personhood and recovery, since it is a fact that social support through family and/or community is often healing (Bell, 2008).

Knowledge should span past individual, internal boundaries into context. The helping professional should know of how counselor style impacts others (e.g., communication). Professionals should be knowledgeable about sociopolitical influences and how racism, discrimination, and oppression impact themselves (e.g., white privilege, own biases) and others. For instance, since 1982, the onset of the "war on drugs," there has been a transformation of the old Jim Crow era into a New Jim Crow, which is deliberately placing black individuals into a new "racial undercaste" (Alexandar, 2010). Now, there are more black men disenfranchised and black families disrupted than in 1870 (Alexandar, 2010; Loury, 2008). Information such as this directly relates to knowledge of a target group/culture (client/patient). General knowledge about a group includes how culture influences personality, help-seeking behavior, and disorder manifestation. It also includes how culture can be destructive (as in the New Jim Crow) or curative. Culture can provide protective factors for people through shaping practices that increase and maintain constructs like optimism, resilience, satisfaction, spiritual wellbeing, wisdom, worldview, connectedness, and trust (Bell, 2011). For example, in some Eastern cultures, collectivism is valued over individualism. Collectivism or collective efficacy/social fabric, alluded to previously, is a protective factor, effective in preventing HIV/AIDS, violence, substance abuse, and strengthening families (Bell et al., 2008; Bell, Flay, & Paikoff, 2002; McBride & Bell, 2011).

Health professionals should also be knowledgeable about bias of assessments and instruments (Fraga, Atkinson, & Wampold, 2004; Langer, 1999) like the Minnesota Multiphasic Personality Inventory (MMPI), as well as measurements.

Culturally competent skills include the ability to take the awareness and knowledge gained and apply it appropriately. Appropriate actions can include additional education, referring when necessary, and obtaining consultation. These skills include self-examination, actively growing in cultural competence, and seeking out multicultural experiences. They also include the ability to decipher whether a problem is due to or influenced by structural discrimination or prejudice (e.g., racism, sexism, heterosexism) and enact apt interventions and actions. A culturally competent professional should also be able to conduct culturally sensitive assessment (e.g., using appropriate instruments, including family). Culture constitutes meaning and shapes the meaning of events for others. If this meaning is ignored, a great deal of pertinent and necessary information is lost in the assessment, diagnosis, and treatment plan. Assessment should not only include the individual's presenting problem and traditional assessment components (e.g., mental health history, substance abuse, past treatment) but also past experiences of societal oppression and subjugation (Bell, 2011).

Prelock et al. (2003) described a culturally competent process used in interdisciplinary assessment of children with autism. Their assessments included genograms and ecomaps (a picture of the family and its context), including and focusing on the family and their environment. Information from assessments (both formal and informal) is used to feed clinical interpretation, which also requires cultural competence. Assessments should also include the strengths of a person's culture and how connected the patient is to their cultural strengths (Bell & McBride, 2011). Cultural competence also avoids the pitfall of misdiagnosis. Three decades ago, Bell and Mehta (1980; 1981) highlighted the problem of misdiagnosis of African Americans who suffered from "manic-depressive illness" as having schizophrenia—a lesson that still has to be reinforced, as misdiagnosis of this population continues to this day (Chien & Bell, 2008). Conflicts or differences in cultural values can lead to miscommunications and inaccurate interpretations. For example, European American culture is doing- and future-oriented. It values planning, scheduling, and a "time is money" philosophy. A clinician or physician who is influenced by these cultural values may interpret a therapy client who is of another culture and late to be resistant when the client actually is committed but has a different values system as it relates to time (Carter, 1991). Furthermore, a physician may interpret a patient to be noncompliant when, in actuality, the patient is restricted by the environment and, thus, cannot comply (Langer, 1999).

Metaphorically, culture is like "water to a fish"—it is pervasive and influences so much of human life but often goes unnoticed. The process of gaining cultural competence on an individual level begins with noticing this water, how it affects one's own daily life, thoughts, and actions, and how it affects others. It then moves to learning about the water, the particles and structures, and how it differs in different places and for different "fish." It culminates with "swimming deliberately" and cooperating, peacefully coexisting, and effectively interacting with others.

ORGANIZATION

Individual cultural competence, especially with helping and healthcare professionals, transcends the intrapsychic processes and interpersonal interactions to target structures. The purpose of these professional services is to heal. Unfortunately, mental health services in this nation

can be deleterious and unintentionally cause further harm through cultural incompetence and microaggressions. Therefore, it can actually contribute to social injustice, widening the gap of mental service accessibility. Thus, mental health clinicians, educators, and researchers must work against this and manifest cultural competence in every sense of the meaning, including countering structural injustice. What good is it to bolster and develop a culturally competent professional if they just to go work in a monocultural, ethnocentric organization that discourages or punishes cultural competence (e.g., accepting certain gifts, doing alternative therapies, working with a shaman)? Thus, professionals must also work to propagate cultural competence in systems—educational, professional, organizations, and society (Sue, 2001).

Organizations have their own culture. For instance, some work as a "machine," with strict and immovable practices and policies, with an operator that pushes a button and all others fall into place; while others work as an "organism," flexible, molding, and growing with time, context, and people (Morgan, 1997). Organizations also exhibit or fail to manifest cultural competence, falling somewhere on a spectrum of organizational cultural competence (Sue, 2001, Jackson & Holvino, 1988; and see Figure 11.2). The monocultural or culturally incompetent organization not only disregards or devalues cultural variation but also stringently adheres to ethnocentric, monocultural policies and practices (Sue, 2001). On the other side of the spectrum, multicultural organizations parallel the multicultural competence in the individual; a truly multicultural organization not only manifests multiculturalism internally by appreciating, soliciting, and being open to diversity of many kinds, but also being proactive, such as fighting oppression and "isms" externally—in society (Jackson & Holvino, 1988).

Interdisciplinary team. Interdisciplinary teams can fall under these same categories of organizational cultural competence and develop the same process of becoming culturally competent (e.g., individual understanding and openness, increasing and respecting diversity within the team, applying culturally sensitive practices, moving toward social justice). As stated previously, a discipline is a culture too. Therefore, the interdisciplinary teams are also susceptible to interpersonal and interprofessional slights or devaluing, which can cause problems on the team and, thus, compromise treatment or the mission. "Similar to ethnocentrism, profession-centrism

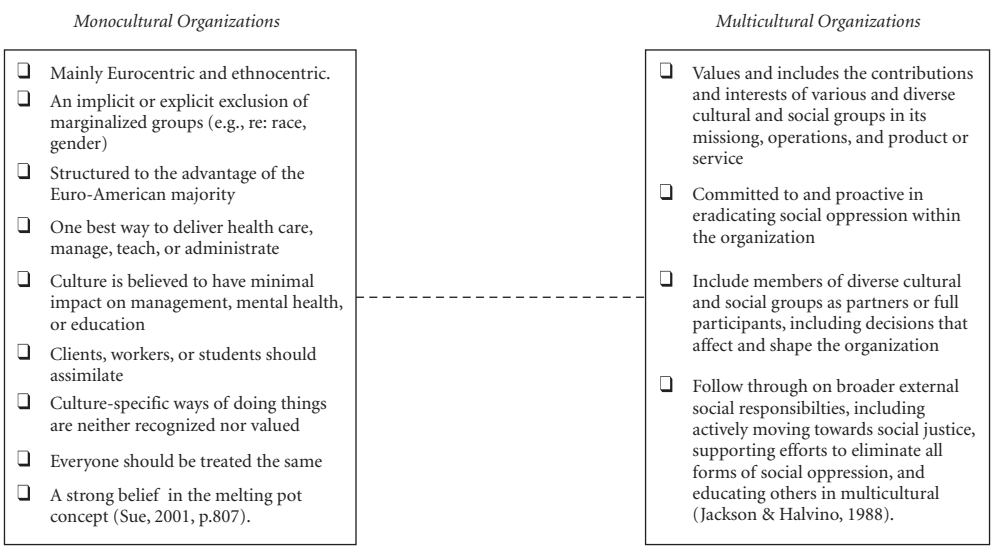

FIGURE 11.2 Spectrum of Organizational Cultural Competence

(professional centric thinking) is a constructed and preferred view of the world held by a particular professional group developed and reinforced through their training experiences" (Pecukonis, Doyle, & Bliss, 2008, p. 420). This profession-centrism, like ethnocentrism, can be abated with deliberate work and training. Perceiving the value or strengths in another profession, especially when working together, can provide an opportunity for utilizing those assets for the good of the client or patient (or achieving the goal, in general). For instance, physicians are educated in the biological bases of human life and how these mechanisms impact health, wellbeing, and sometimes even behavior. Social work has a rich tradition of studying and addressing the intersection of the individual, family, community, and ecology. There is much for each profession to learn from one another. When the two are combined, the picture of the human being becomes clearer and more accurate.

Various scholars have described experiences, findings, and conclusions in creating interprofessional cultural competence. Two core principles in good interdisciplinary functioning and cultural competence are effective communication (Lu, 2003) and true collaboration (Marcus, 2000). Reich and Reich (2006) described various pitfalls to plan for and avoid in doing culturally competent interdisciplinary work, including 1) tokenism: do not place disciplines on the team without an intent to equally include them and integrate their knowledge and skills; 2) silence and power: ensure that power is equally distributed and no person's opinion or knowledge is neglected (e.g., in data, resource allocations, and access to information); and 3) disciplinary policing: people may be averse to others or themselves' crossing disciplinary boundaries. Peer-reviewed journals and other aspects of professions and professional practice (e.g., ethical standards, worldviews) are seen as superior, and a person may get criticized by others in group for branching out. Pecukonis, Doyle, and Bliss (2008) suggested, in enhancing intraprofessional cultural competence and addressing some of these dilemmas, the professional should have a "good IDEA":

Interaction with people from other health disciplines to gain familiarity with other disciplines;

Data (accurate) on other professions and on each individual as a person and not just a profession;

Expertise in effective communication with other disciplines—being able to both communicate one's own discipline to others, including values and principles, and openly listen to others;

Attention to one's own discipline—its culture, history, values, norms and attention to others or "professional self-reflection," should be able to discuss similarities and differences between professions with one another.

Levinson and Thornton (2003) suggested six components in successful interdisciplinary teamwork. Although their team's process was general and not related to culture, medicine, or psychology, their lessons learned are essential in interdisciplinary cultural competence. According to them, each team needs to: 1) have a strong leader, 2) check their egos at the door, 3) have a commitment to the project, 4) have rules of inclusiveness that are respected and maintained, 5) have young researchers focus on their discipline—for professional growth and clout, and 6) have a focus on developing the next generation of scientists. Strong leadership, especially in a culturally competent interdisciplinary team, is essential (Bell, McBride, Redd, & Suggs, 2012). Culturally competent leaders must be aware of "biases and assumptions" that

exist in their organization or team. They must be willing to take unpopular positions on social issues to promote social justice, target oppression, and address injustices in their team, and recruit people who are underrepresented in their profession (Arredondo, 2008). Others have found easy yet efficacious tactics that can be used with those outside of leadership, supplementing some of the aforementioned core principles with individual roles, including a "jargon buster" and "equalizer," who ensures everyone has equal "air time" and is respected (Prelock et al., 2003).

CULTURAL COMPETENCE TRAINING

Regardless of the process or structure, cultural competence often begins with humility (Tervalon & Murray-Garcia, 1998), education, and/or experience. Training can provide (or elicit) each of these scaffolds. Cultural competence training has been found to be an effective tool in moving one along in the process (Beach et al., 2005; American Psychological Association, 2003; Webb & Sergison, 2003) and has been suggested for growing cultural competence in clinical interdisciplinary teams (Lu, 2003). It has caused statistically significant improvements in counselors' and doctors' behavior with clients and patients, which had improvements in clients' health (Tang, Fantone, Bozynski, & Adams, 2002; Langer, 1999). Particularly in a medical setting, training has been shown to enhance experience with sociocultural issues, understanding of the importance of and relationship among sociocultural background, health, and medicine, and improve the doctor–patient relationship (Tang, Fantone Bozynski, & Adams, 2002). Such training can come in various forms, from small-group discussion, lecture, immersion (Warner, 2002), case examples, storytelling or sharing experiences (Papadopoulos, Tilki, & Lees, 2004), personal journaling, videotaping and feedback, and professional role modeling from one's own and other cultural groups (Tervalon & Murray-Garcia, 1998). Regardless of the methodology used within the training, it should focus on cultural understanding and awareness over stereotypic information of a particular group (e.g., providing a "menu" for different groups, such as "in treating Latinos, you should…"; Webb & Sergison, 2003).

MEASURING CULTURAL COMPETENCE

As with any program or professional activity, knowing the value or effect of the initiative helps to affirm or disconfirm the validity or soundness of practices and guide future practice. Fortunately, there are ways that we can evaluate and measure cultural competence. There are several reliable and valid assessment instruments (Suarez-Balcazar et al., 2011; Doorenbos, Schim, Benkert, & Borse, 2005). The Cultural Competence Assessment (CCA) has been found to be the best measure for competence with healthcare providers. The CCA is a valid and reliable instrument for measuring cultural diversity experience, cultural awareness and sensitivity, and cultural competence behaviors and is especially applicable and relevant for healthcare providers. It was also made to fill the gap in available cultural competence instruments for interdisciplinary healthcare teams (Doorenbos et al., 2005).

CONCLUSION

In the previous decades, culture and diversity were unrecognized and deeply undervalued. This pervasive ethnocentrism has hindered national progress in nearly all areas, including education, economics, and national health. Fortunately, in recent years, the value of diversity and the importance of culture have started to be recognized and used. Now there is sound research that evidences the need to focus on and include cultural variation. From the harm of microaggressions, cultural ignorance, and color-blindness to the rectifying effects of cultural responsiveness, culture competence can now soundly be spotlighted and integrated throughout service development and delivery. Despite the deleterious aftermath of cultural incompetence, we can remedy our social situation with cultural competence, which can be attained through awareness, humility, and training. There is enough empirical support for widespread endeavors, such as requiring all professions to take cultural competence training and making cultural competence an ethical imperative (Niermeier, Burnett, & Whitaker, 2003). "To top it off," we are able to measure our progress with reliable tools. Recognizing the data, evidence, harm, and corrective possibilities, there is no better time to move toward making cultural competence ubiquitous.

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