A Qualitative study of mental health practices with Culturally and Linguistically Diverse (CALD) Clients

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Practitioners are expected to be culturally competent in order to offer appropriate counselling to culturally and linguistically diverse (CALD) clients in Australia. However, not much is known about their practices and therapeutic experiences with CALD clients. Using a qualitative approach, 15 mental health professionals from different disciplines were interviewed about the counselling process as well as their practice with CALD clients. Participants who had worked with CALD clients in a range of settings were invited to participate. Themes identified by the thematic analysis highlighted the importance of awareness and skills over knowledge, suggesting that respect and rapport could compensate for a lack of cultural knowledge. Further, practitioners reported that knowing where to find cultural information as it was required was more important than being expected to know this cultural knowledge. The findings supported concepts from existing models of multicultural competence and identified concrete practices associated with these constructs, thereby narrowing the gap between the theory and practice of cultural competence.

Australian society is culturally diverse with more than 200 language groups settled in this country (Australian Bureau of Statistics, 2013). After taking into account Aboriginal and Torres Strait Islander peoples, a quarter of the population is from culturally and linguistically diverse (CALD) backgrounds (National Medical Health and Medical Research Council, 2005). CALD clients generally access mental health services at lower rates and experience poorer clinical outcomes compared to mainstream clients (Akutsu & Chu, 2006; Bhugra & Arya, 2005; Steel et al., 2006). Poor communication, language differences, stigma, lack of appropriate information, prejudice towards minorities, culturally insensitive services, and cultural differences with practitioners have been identified as barriers to service access, and as factors which impact upon clinical outcomes amongst CALD populations (Spanierman, Poteat, Wang, & Oh, 2008; Stolk, Minas, & Klimidis, 2008). The mental health and well-being of CALD individuals is a national health priority in Australia and health policies consider culturally sensitive and appropriate services by culturally competent clinicians vital for ethnic clients (Mental Health in Multicultural Australia, 2012). In spite of the endorsement of multicultural counselling competency, there is limited information about how this is incorporated by the Australian clinicians into their practice. It is therefore important to examine the process issues and the competencies that work with CALD clients.

Multicultural Counselling Competency

Multicultural counselling is the therapeutic interaction between a client and a practitioner, who are from different ethnic or cultural backgrounds (Hernandez, Nesman, Mowery, Acevedo-Polakovich, Callejas, 2009). Several models of Multicultural Counselling Competency (MCC) have been proposed during the last three decades (Constantine & Kwong-Liem, 2003; Mollen, Riddley, & Hill, 2003). The one that is the most researched is Sue and colleagues' (Sue, Zane, Nagayama Hall, & Berger, 1982) tri-component model of MCC. The model's three components were identified as *awareness*, *knowledge*, and *skills* (Yan & Wong, 2005). *Awareness* involves the practitioner being aware of their own culture, attitudes, beliefs, and values, possible multiple 'world views' inherent in the therapeutic dyad, power differentials, personal biases and racial attitudes, and the effect of these on the therapeutic process. *Knowledge* encompasses the practitioner's knowledge of the CALD client's culture (including social norms and culturally specific disorders), worldview, and expectations of counselling; whilst *skills*

denotes the practitioner's ability to practice effective cross-cultural intervention strategies. These competencies were welcomed as positive developments in the field of counselling and psychology and formed the bases for training programs and accreditation processes (for a review, see Worthington, Soth-McNett, & Moreno, 2007). However, they have also been severely criticised (e.g., Collins & Arthur, 2005; Thomas & Weinrach, 2004).

Researchers and practitioners, through theoretical papers, have debated the components of Sue and colleagues' model of MCC. The notion that practitioners can actively use self-awareness to achieve a state of cultural neutrality is questioned (Yan & Wong, 2005). Self-reflection is considered difficult unless the practitioner is disadvantaged or disabled in some way (Collins & Arthur, 2007). Awareness of racial biases and privileges of the majority can trigger defensive reactions (Spanierman, Poteat, Beer, & Armstrong, 2006). Additional criticism is levelled at the inherent assumption that clients are passively encapsulated within their cultural mores. Another debate centres around the importance of and reliance on culture specific knowledge versus taking an individualistic approach with a CALD client (Scott & Borodovsky, 1990; Stuart, 2004). However, others reject the unrealistic belief that practitioners should be experts in the mores of all cultures they will encounter (Dyche & Zayas, 2001; Tsang, Bogo, & George, 2003). Thomas and Weinrach (2004) argue that reliance on such information leaves the practitioner vulnerable to perpetuating stereotypes. Further, controversy remains around the conceptualisation of MCC as a set of skills consisting of theoretical models and intervention strategies for specific cultural groups (Weinrach & Thomas, 2004). This would imply that therapy is a unidimensional exchange from practitioner to client (Stolle, Hutz & Sommers-Flanagan, 2005; Yan & Wong, 2005). Further, it would be impossible to develop assessments and interventions for each specific cultural group (Collins & Arthur, 2010).

Even though more comprehensive models have also been developed (Alladin, 2009; Marsella & Pederson, 2004), Sue and colleagues' model was a good starting point for reflection among the practitioners as it has remained relatively stable over the years (Worthington, et al., 2007). The mental health professions have now adopted culturally competent practice as an ethical responsibility (Kirmayer, 2012). Researchers and practitioners have continued to examine what constitutes cultural competence and the most effective approaches when dealing with CALD clients (Collins & Arthur, 2010).

Multicultural Competent Best Practice

MCC is a paradigmatic shift or philosophical stance, whereby practitioners become aware of personal values, background, biases and their impact on clients, rather than striving to meet a benchmark of skills criteria (Adams, 2010; Bingham, Porche-Burke, James, Sue, & Vasquez, 2002). Practitioners undergo an ongoing process of understanding themselves as a racial and cultural person, while attempting to adopt a non-racial identity and ethno-cultural empathy to work with a client (Spanierman et al., 2008). Stuart (2005) and Sue et al. (2009) described practitioners' responses to diversity as the appreciation of differences amongst clients (within group differences); the awareness of culturally mediated identity; and the perspectives that MCC is an ongoing process, rather than a discrete set of attainable skills. Scott and Borodovsky (1990) elaborated on the concept of knowledge and stated that practitioners require some knowledge of the client in order to demonstrate accurate empathy. Even though it is not possible to know about each and every culture and tradition, practitioners can overcome this hurdle by recognising that CALD clients are part of cultural groups, which are subjectively significant to them and can be further explored (Stolle et al., 2005). Arrendondo and Perez (2006) assert that cultural competence is most effective when it incorporates service provision that is subjectively meaningful to the client, rather than what is perceived to be objectively meaningful (as inferred by group membership). Further, Caldwell et al. (2008) reiterate the commonly held stance that humans can all identify with each other in the

common ground of diversity. Thus, competent practice should incorporate many of the cultural competencies, regardless of the cultural similarities or differences between the client and practitioner.

Bingham et al. (2002) stated that there is no one theory, approach, or set of skills that can account for all phenomena of human behaviour. An effective working alliance and relationship are considered vital for multicultural counselling (Collins & Arthur, 2010). A relationship which is based on an agreement on goals, mutual trust, and respect is effective in facilitating change (Collins & Arthur, 2010). Stuart (2005) stresses the importance of respect, as respect can compensate for the lack of cultural knowledge. Collins and Arthur (2010) emphasise the significance of strategies that practitioners can use to critically analyse the assumptions and rationales of various models of assessment and intervention to determine their relevance and effectiveness with each client. Further, Caldwell et al. (2008) and Salvin, Rainer, McCreary, and Gowda (1991) state that practitioners must be flexible and willing to incorporate modified approaches in order to be effective. Bingham et al. (2002) assert that multicultural approaches need to include factors extending beyond race, such as gender, socio-economic status, disability, and sexual orientation, as all of these factors contribute to cultural experiences held by both practitioners and clients.

Several authors have argued for a socio-anthropological approach to work with CALD clients, incorporating the use of 'explanatory models' (Bhui & Bhugra, 2002; Kleinman & Benson, 2006). Kleinman and Benson (2006) conceptualised explanatory models as a mini-ethnographic approach for qualitatively exploring clients' multilayered perspectives on their illnesses (including illness narratives and social, taboo, and spiritual contributing factors), and breaking down the unidirectional nature of traditional mental health practice. Some evidence suggests that this approach comprises culturally competent practice, with increased client satisfaction in cases where clients felt practitioners shared their model of understanding illness and treatment (Callan & Littlewood, 1998).

Caldwell and colleagues (Caldwell et al., 2008) qualitative study outlined the following factors as key elements of effective MCC: Being able to draw on similarities among people, focussing on the client culture without factoring in one's own cultural identity, acknowledging the cultural differences, offering services aligned with the cultural competence model supported by the literature, seeking resources, such as interpreters, consultants available for CALD clients, using skills that foster empathy and understanding, and finally self-integration in the form of awareness of one's own biases limits, client's world view, and culturally appropriate interventions. Neville, Spanierman and Doan (2006) emphasised addressing issues of culture, race, and inequalities to avoid premature termination of therapy and low level of service utlilisation. Further, Mollen (2011) emphasised the role of training to enhance cultural competence of the practitioners and research to evaluate and refine the model.

Gaps in the Literature

Even though the MCC is internationally recognised, the multicultural counselling literature is lacking in some areas and is peppered with contradictions (Weinrach & Thomas, 2004). Previous research has predominantly concentrated on theory building, whilst only a minority of studies focussed on the counselling process, practicalities of practice, and actual behaviours and skills used by practitioners with a view to build competencies within the profession (Arrendondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005). This deficit arguably results in many practitioners relying on 'expert opinion' to guide practice in the absence of empirical support (Tsang et al., 2003). Further, a reliance on self-report measures in the MCC literature has been problematic, as findings are based on participants' self-perceived skills, abilities, and practices and there has been no control for participants' biases and a lack of awareness of their skills deficits (Howitt, 2013). Therefore, it is important to prioritise studies exploring process issues and techniques currently found to enhance (or detract) from service provision to CALD populations (Hernandez et al., 2009; Sue

et al., 2009). These strategies should also be relevant and generalisable to the profession, and inform current practices (Truong, Paradies, & Priest, 2014). Finally, it is important to note that there is a scarcity of research on MCC in Australia (Khawaja, Gomez, & Turner, 2008; Lee & Khawaja, 2012). Although MCC is considered an essential component of practice, there is a reliance on models and literature emerging from North America and Europe. Little is currently known about practitioners' current practice in Australia.

The Present Study

The present study recruited multi-disciplinary mental health practitioners in Australia to explore their practices and therapeutic experiences with CALD clients. Semi-structured interviews were used to collect data from mental health service providers. A qualitative approach was employed to allow participants to introduce concepts which they felt were salient or valuable to work with CALD clients. Further, this approach was used to identify themes of the practical skills, strategies, and behaviours that were being used by practitioners, practices they found to be helpful or unhelpful, and how these aspects reflect key concepts espoused within the literature.

Method

Participants

Participants were 15 mental health professionals (seven males, eight females) from the Brisbane (Queensland, Australia) metropolitan area. Participants' ages ranged from 26 to 67 years (M = 45.6, SD = 12.7). Professional experience ranged from 1 to 30 years (M = 12.4, SD = 10.7). Whilst 53.3% of the sample (n = 8) identified themselves as Anglo Saxon, 46.6% (n = 7) identified themselves as coming from a CALD background.

The sample was representative of the mental health service provider sector, including registered clinical psychologists (n = 7), counselling psychologists (n = 2), general psychologists (n = 2), social workers (n = 2), counsellor (n = 1) and psychiatrist (n = 1). All participants had experience with CALD clients; some practiced specifically within the target group, whilst others had engaged with CALD clients in the context of a more general practice.

Materials

Brief demographics form. An 11-item form was used to collect information regarding age, experience, education, professional context, and approximate ethnicity of participants' client base (i.e., the percentage of mainstream vs. CALD clients).

Interview. A semi-structured interview with one open-ended non-directive question and several prompts was used. The key question was, "Tell me about your experiences with culturally and linguistically diverse (CALD) clients?". Prompts, which were used when required or applicable, were, "Tell me about your experience engaging the client", "Tell me about your experience with developing rapport", "Tell me about your experience with gathering information/data", "Tell me about your experience with communication", "Tell me about your experience with contracting the client for ongoing therapy/committing to therapy", "Tell me about your therapeutic approaches", and "Tell me about your experience with determining a diagnosis". The preceding prompts were followed by, "What do you feel was helpful and what do you feel was less helpful?" as required. Also, participants were asked, "What were the general outcomes?" or, "What were the reasons of these outcomes?" as relevant.

Procedure

Mental health professionals were notified of the study at professional conferences, and via telephone calls and emails to clinics and organisations. Snowball recruitment, where initial participants nominate potential participants from their social network (Salganik & Heckathorn, 2004) was also employed. Prospective participants contacted the researchers via email and an interview time was arranged at their mutual convenience. Participants were provided with a copy of the brief demographics questionnaire (to be completed prior to the interview) and a copy of the interview schedule for their perusal. Participants were given the opportunity to ask

any questions prior to the interview, either via email or in person on the day of the interview.

Upon arriving at the nominated venue (in the majority of cases, this was the participant's workplace), the participant gave their completed questionnaire to the interviewer and the tape recorder was set up and recording began. Interviews ran for approximately 45-60 minutes. Prompts were kept to a minimum and used only in instances of providing starting points for participants, or as an invitation for them to expand on points they had introduced to the interview. Participant recruitment for the study ceased once participants failed to introduce new topics, and the information provided became redundant. All interviews were conducted by the second author, who was a second year Master of Clinical Psychology student.

Data Analysis

Interviews were transcribed and analysed by the second author in consultation with the first author, a Clinical Psychologist with an ethnic background and extensive experience in working with CALD clients. Qualitative data analysis software (NVivo 9.0, 2010), was used to facilitate data analysis by searching for combinations or patterns of wording and identifying themes in the transcripts. Transcripts were read and re-read in order to get a global sense of the participants' accounts and experiences (Howitt, 2013). Repetitive patterns and ideas were noted. "Key words" were used to code these ideas as "sub-themes". Links among key words were recognised and they were grouped together to identify emerging main themes within and across participant interviews. Thus, these overarching themes represented specific ideas and were labelled meaningfully using "terms or phrases". The salience of the themes was determined by examining the overall time spent discussing each and every theme. Subsequently, the amount of time spent on the themes within and across the interviews was used as a criterion to prioritise themes.

Once the themes were finalised, a researcher who was unfamiliar with the study was allocated a randomly selected 10% of the transcripts in order to establish inter-rater reliability. Key words and phrases that captured sub-themes and overarching themes were discussed and described to the second rater. This rater then analysed the data, which was compared with the original coding. Further analysis was conducted by calculating the percentage of agreements between raters. The calculation suggested a significant level of agreement (80%) (Howitt, 2013). Data from the demographics questionnaire were entered into SPSS for a descriptive analysis of the sample.

Findings

Themes that emerged from the data analysis and interpretation are organised in line with the therapeutic process. The initial section comprised of data pertaining to steps taken *prior to contact* with clients. Subsequent sections contain information pertinent to initial *contact* with clients, followed by data relevant to *interventions* employed with clients. *Experiences with and interpretations of outcomes* follows these sections, including factors which affect adherence and outcomes.

Prior to Contact

Themes emerging during discussions around service provision to CALD clients suggested the necessity of taking several steps prior to therapeutic contact. Collecting *cultural knowledge* was one of the salient sub-themes discussed by all participants in their preparation for work with CALD clients. Participants described several positive and negative effects of developing a relevant base of cultural knowledge prior to engaging clients. *Positive effects of cultural knowledge* included: Gaining an understanding of courtesy rules and protocols for addressing the family; informing about interventions; and helping to differentiate individual traits and cultural factors from pathology. Cultural knowledge also aided in building rapport. One participant reported:

> Sometimes if people realise that you do… have some knowledge about their background and culture… they know you're interested in the area so you have a genuine sort of interest in providing support and assistance (female, Social Worker).

When queried as to whether one personally retains cultural knowledge,

participants stated the impracticalities of knowing all cultures, purporting that it was more important to know where to get this information as it is required. Numerous *sources* of multicultural information were identified by participants, including: Bi-cultural workers, colleagues' experiences, community leaders (who can also illuminate acculturation issues), clinical consultation services, multicultural affairs groups (who have compiled a directory of various cultural groups), books, the internet, and State's Transcultural Mental Health Services. Clients and their families were also cited as a rich source of information, especially if practitioners adopted a 'not-knowing' stance.

Some participants reported negative aspects of incorporating cultural knowledge, including the risk of stereotyping and an erosion of practitioners' self-efficacy due to unrealistic expectations of assimilating vast amounts of knowledge. One participant stated:

> You can end simply feeling that you're never good enough, to work with people … I think one can become preoccupied with what we don't know about a particular culture (male, Counsellor).

When discussing the impact of culture on the therapeutic space, seven participants stated that whilst they were aware of the client's ethnicity (*cultural awareness*) this was not the focus of therapy. However, these participants stated that if an impasse is reached, client's ethnicity could be a interfering therapy and such situation requires an exploration.

Contact

This theme included sub-themes which emerged during discussion around the therapeutic process, once therapeutic *contact* was reached. When engaging clients it was reportedly important to *reserve assumptions* despite having cultural knowledge and to adopt a *curious approach*, which extends to curiosity about the client's perceptions of the therapeutic process. *Respect* and *genuineness* were highly endorsed by participants, and cited to be more important than cultural knowledge. One participant said:

> I think most people that I know who are from a different cultural background don't have a problem with professionals as long as they are treating them with respect… it doesn't matter if they know greetings or what the cultural processes are, because most people from a CALD background can adapt to the mainstream culture (male, Psychiatrist).

Participants stated it was important to *establish roles* early in the relationship in order to avoid confusion regarding goals, aims, and reasons for therapy. It was considered important to clarify confidentiality early, and to reinforce continuously. However, other boundaries were best kept flexible as long as they were complimented with regular supervision to ensure that the therapist offered best practice. As one participant commented:

> There comes a time where you have to say "look I'm a psychologist, this is how we work, I can go so far", and be flexible, "but some things I can't do" (male, Psychologist).

Rapport emerged as a salient theme for effective therapeutic contact with CALD clients. Participants stated that rapport was aided by *self-disclosure*, and discussing culture-bound symbolic words (*specific terminology*). Spending the opening minutes engaging in *problem-free talk*, such as discussing interests, family, or culture, helped by engaging clients around meaningful and safe topics, and also offered therapeutically important information. Bi-cultural workers reportedly built rapport around shared language and cultural factors, whilst four participants felt redirecting clients to other services or taking an advocacy role helped demonstrating a preliminary willingness to help.

While discussing the topic, participants mentioned several *barriers* to rapport building. The client's tendency to expect the practitioner to be an authoritarian expert with knowledge to solve problems compromised a collaborative approach and clients' willingness to challenge therapists. Further, client's inability to accommodate mental illness in their world view also hindered the rapport building. One participant felt it was

important to offer an expert opinion, as a failure to do this may damage rapport due to paternalistic native approaches. It was therefore important to find a balance between this approach and Western training of guided discovery. Moreover, one participant stated that authority is based on accuracy, therefore it is important to continuously check with clients that you are on-track as failure to do so could result in premature termination (as clients will not challenge therapists).

Interpersonal communication emerged as a salient feature in contact with clients, and was strongly linked to building rapport. Ineffective interactions could result in frustration leading to impatience and acquiescence on the part of the practitioner. According to participants, communication difficulties could also lead to increased anxiety in the therapist. One participant stated:

> It wasn't so much the issues that they had that worried me; it was the communication and stuff that I really noticed about those clients (female, Clinical Psychologist).

Participants reported that in cases of mild communication difficulties, basic reflective listening skills were effective when complimented by simplified language and avoidance of jargon or colloquialisms. It was important to be aware of varying *levels of language ability*, as some clients had good superficial English, however this remained rooted in cultural idioms.

In cases of severe communication difficulties, several participants considered *interpreters* as a means of enhancing service provision. However other participants considered interpreters unhelpful due to a general lack of mental health training, doubtful reliability, and triangulating effects on the therapeutic relationship.

Interventions

When asked about their experiences in providing therapy to CALD clients, participants discussed several therapeutic processes and experiences with assessment, diagnosis, and incorporation of intervention strategies. Salient themes emerging from discussions around the *therapeutic process* were conceptualised as a range of techniques and approaches that one would use with all clients in the interest of providing the best therapy possible. These included having *self-awareness* of one's own values, training, preferences (including preferences for certain clients), and paradigms. These techniques also included checking the client's values and theory of how change will occur, and *creating a safe space* for the client.

Participants felt therapy was essentially the same process with mainstream and CALD clients, yet service provision with CALD clients was a slower and lengthier process (*slowing it down*) due to: The time taken to build rapport, communication difficulties, and extra time during the history-taking phase to explore culture and its meaning and impact on clients. In efforts to engage clients in the therapeutic process, six participants stated they would make a blatant *statement of ignorance*. Participants stated that one of the benefits of adopting this technique included its ability to offer permission to clients to challenge the therapist.

In discussions around assessment, two participants stated that it was helpful to ask clients for their *explanatory models*, or how they conceptualised the problem and its solution. This was deemed to be effective as exchanging models increased clients' involvement in dialogue, and informed treatment. Furthermore, when conducting assessments, it was important to explore the client's level of acculturation. Participants highlighted the importance of checking the connection to the country of origin, the amount of time spent in Australia, and acculturative effects on family, especially in cases of trauma, as its impact could damage one's ability to adapt. A male psychologist advocated for the use of the cultural formulation in the DSM-IV-TR (the classification system used at the time of data collection) as a structured process to gather this information. Two participants felt it was appropriate to ask clients directly, or their families (with the client's consent); however, if hidden motives were suspected, it was important to validate information with other professional sources.

Some assessors adopted Western

approaches to assessment, with slight alterations to accommodate for cultural factors. One practitioner illustrated this point by stating that he has expanded the biopsychosocial model by accommodating spirituality and culture. Another practitioner adjusted standard questions in order to make them more culturally relevant. According to him:

> Such questions as "you feel the radio has special significance for you?"… but within a different culture, it may be much closer to the notion of "do you hear people speaking to you who are not present?" (male, Clinical Psychologist).

Reliability was an issue with CALD clients as participants felt they were less able to identify and accurately gauge non-verbal cues and expressions, therefore increasing the propensity for misdiagnosing clients due to impaired second language abilities (i.e., regression to the first language during times of stress). In order to control for this, participants from some services involved bi-cultural workers, either via video-conferencing or joint assessments, to facilitate a *cultural assessment* using cultural protocols. This strategy assisted clients and helped them to feel safe engaging in the process, even in cases where the clients themselves did not know a lot about cultural processes.

Participants stated that it was also important that therapists are flexible with their approach and are able to tolerate ambiguity to avoid *mislabelling* culturally appropriate experiences. This is of particular importance as participants reported that such mislabelling in the past has contributed towards a mistrust of psychiatry (and mainstream health services generally) amongst ethnic communities. One participant indicated:

> Sometimes, this is not with all mainstream professionals… because they think "this is from a different culture it's hard to interpret" they see a sign of something, they put people in boxes and they concentrate on "this is what they have" you know (female, social worker).

Therapeutic Style

Therapeutic style emerged as a salient theme in discussions around interventions and therapeutic processes with CALD clients. Three participants identified narrative, constructionist and solution focussed approaches as successful vehicles for treatment with CALD clients. These approaches were reportedly suited to CALD clients due to their 'not-knowing' stance, the use of reframing to avoid blaming, and the client centred approach which was not overly structured or interpretive.

One participant stated that family therapy was an effective and culturally appropriate style of therapy. Use of the family as the treatment team was seen to accommodate the need to keep mental health problems within the family (due to stigma), and prevented possible erosion of the family system caused by individualistic interventions, which could be counterproductive. Furthermore, the use of ceremonies in some family therapy approaches was felt to emulate the approach of some traditional healers, who operate on the assumption that individuals are seen within the context of their family, and those who seek help are wanting to be told what to do, and are then willing to do it.

Mixed results were reported from participants who had employed psychodynamic, non-directive, and cognitive behavioural approaches. Cognitive behavioural techniques employed included: Psychoeducation, problem solving, identifying cognitive distortions, time-management techniques, and use of the white board to externalise culture and the acculturative process. Psychoeducation was widely nominated as an effective intervention, especially for exploring variation between Western culture's management of mental health issues, versus how this might be managed in the client's country of origin.

Flexibility of approach and 'going the extra distance' was also found to be effective, as was the collaborative exploration of what was helping and what was unhelpful, which could lead to the incorporation of client suggested interventions contributing to

positive clinical outcomes. One participant said:

> So it's not so much buying into "people believe in spirit possession" or whatever it might be, you know, it's not about right or wrong, or you know values, belief systems all the rest of it. It's about clinical outcomes (male, Psychologist).

Experiences with and Interpretations of Outcomes

Participants highlighted the importance of the *therapeutic relationship* for *facilitating adherence,* and cited this as being more important to outcomes than having cultural knowledge. One participant stated:

> The first thing… is the trust, and the alliance, with the person. I have to believe in that person, and they have to trust me. And that is part of the healing process (female, Counselling Psychologist).

Communication again emerged as a salient feature with five participants stating that the more limited the communication, the more difficult it was to build rapport (*reliance on communication*). This was partially attributed to the therapist feeling more comfortable and less anxious if communication was not impeded, as some participants felt that repeatedly asking questions to check understanding could re-create experiences of interrogation for survivors of trauma.

When discussing experiences around *assessing outcomes*, one therapist reported they would ask the client themselves at the end of each session if the client felt it was worthwhile or beneficial. Another participant stated that whilst it is possible that drop-out could be assessed as being indicative of a negative outcome, they conceptualised CALD clients as looking for expert opinion and guidance to solve problems within one or two sessions, and were not necessarily after long-term therapy. Therefore, drop-out could alternatively be interpreted as the feeling that the client no longer needed the services of a therapist. One participant pointed out:

> So, probably I wouldn't call it adherence because that has the idea that if they stop seeing you they're not adhering whereas probably the future expectation is you might be an expert, I want your advice and there's no point seeing you again. So I think it has to be treated in that way (male, Clinical Psychologist).

Discussion

This qualitative study explored the practices and experiences of practitioners offering services to CALD clients in Australia. The findings identified strategies that participants found helpful, in conjunction with issues to be aware of, when working with CALD clients. They also identified concrete practices, useful to deal with the biases and other disadvantages minorities sometimes encounter in Australia. Overall, the strategies were consistent with the concepts within the literature.

The thematic analysis indicated that *skills* and *self-awareness* were more important to cultural competence than cultural *knowledge*. Thus, the present study found it more important to approach CALD clients with respect, to build good rapport, and to use sound clinical skills (i.e., curiosity, reflective listening, and exploration of values) than it was to know about cultural mores. Similarly, the therapeutic relationship and working alliance have been considered vital by previous researchers (Collins & Arthur, 2010; Kirmayer, 2012). Further, these findings supported Stuart's (2005) views that awareness and skills were the key factors of culturally competent practice. Stuart's findings suggested that a lack of cultural knowledge could be compensated for by rapport and being respectful. This finding arguably echoes sentiments reiterated by Arrendondo et al. (2005), which implied that one may engage all people universally via respect, due to shared differences.

Whilst the present study found knowledge around cultural factors to be important for informing assessment and therapeutic processes, it was not as important to have this knowledge prior to contact, as this could be gained from the client themselves (with sufficient rapport and communication). Comparative with

suggestions by Scott and Borodovsky (1990), the present study found that some knowledge could inform rapport building; however, this also increased the risk of stereotyping (Thomas & Wenrach, 2004). Therefore, it was more important to slow down the therapeutic process and spend more time building the therapeutic relationship. This latter finding was analogous to Caldwell et al. (2008) findings, emphasising the importance of slowing down the process and attending to the client as a source of information rather than risking stereotyping.

The current study found that rapport building was enhanced by self-disclosure and providing a period of problem-free talk prior to the discussion of presenting issues. Flexible boundaries are important in general with all clients, but they are even more important when working with CALD clients, who may bring a range of practical issues that are not part of a practitioner's role. Subsequently, acting outside of a traditional therapeutic role (e.g., advocacy or referral to services for practical issues) is what the practitioner may find themselves doing. These findings are consistent with Caldwell et al.'s (2008) sentiments that cross-cultural work requires modified practice in order to be effective. Finally, it was considered more important and realistic to be aware of where to obtain relevant knowledge when it was required, rather than practitioners carrying this knowledge with them. This finding supported the view of several researchers who proposed an unrealistic expectation that practitioner must be versed in the cultural mores of all clients that they will encounter (Dyche & Zayas, 2001; Tsang et al., 2003).

Stolk et al.'s (2008) findings that communication was a salient issue with CALD service provision was further supported by this study. The present study found that communication difficulties could impair rapport due to effects on therapists' anxiety and difficulties imparting concepts. Therefore, it was important to be aware of clinical services which could be incorporated to enhance service provision with CALD clients. Interpreters were considered valuable tools by some participants in the face of communication difficulties; however, their incorporation into therapy carried several caveats. Referral to, or incorporation of, cultural consultants was considered a preferable addition to therapy with a view to facilitating communication and culturally relevant assessment and diagnosis. As such, these findings are comparable to those of Caldwell et al (2008), who reported the importance of incorporating cultural consultants as a key step towards effective practice with CALD populations.

CALD clients could be part of various cultural groups and subgroups. Therefore, it is important to explore their perceptions and relationship with their own culture. This is consistent with previous findings, (Arrendondo & Perez, 2006; Stolle et al., 2005), which considers it important to gain an understanding of the subjective meaning of the culture for the client. The present findings were also similar to concepts espoused by Bingham et al. (2002), highlighting the importance of incorporating factors beyond ethnicity, such as gender, socio-economic status, and sexuality.

Participants in the present study reported mixed experiences with specific therapeutic approaches with CALD clients. Family therapy was reportedly effective due to a culturally appropriate incorporation of the family, as were constructivist approaches (i.e., narrative therapy and solution focussed therapy) due to their inter-subjective and curious stance. This finding supported Stuart's (2005) view that self-awareness was important due to the impact of therapists' values on their interpretation of events. However, participants deemed this an important trait for therapy with any client, and not specifically for those from a CALD background. Psychoeducation was also reportedly an important intervention, possibly due to a bridging effect between competing paradigms of treatment (held by the therapist and client). Ultimately, current findings suggest that it is important to critically examine the modalities in order to select the interventions or techniques that best match with the client's needs (Collins & Arthur, 2010). Additionally, these findings support Stuart's (2004) and Scott and Borodovsky's (1990) advocacy for individualistic models of cross-cultural service provision, rather than

LaFromboise and Foster's (1992) cultural literacy model.

Findings from this study indicated that CALD clients would take active measures to adapt to Western methodologies, and to be understood by service providers (e.g., actively attuning to or being aware of the therapist's confusion). Therefore, the current findings supported previous criticisms of models which regard clients as passive agents, incapable of operating outside the constraints of their culture's influence (Yan & Wong, 2005).

This study also supported Neville et al. (2006) view that practitioners do not currently employ *specific* cross-cultural techniques, and instead utilise mainstream therapeutic practices. Participants in the current study detailed techniques used to aid engagement which were analogous to the explanatory model as described by Kleinman and Benson (2006). Employment of these techniques was additionally reported to inform treatment, however, once again, these techniques were not exclusively used with clients from CALD backgrounds.

This study found limited support for some researchers' recommendations of addressing culture explicitly and early in the therapeutic process (Sue et al., 1982). Rather, the present findings suggest that practitioners were more likely to be mindful of cultural factors to be raised in the event of an impasse, or discuss cultural phenomena as part of problem-free talk and rapport building (including their own experiences with the client's culture). Therefore, the current study presented a picture of practitioners holding an awareness of clients' culture as an extra salient factor in therapy. This finding challenges Stolle et al.'s (2005) sentiments that it is insufficient to approach cross-cultural work as Western practice with an additional awareness of the client's culture, due to the implicit failure to make the paradigmatic shift to multicultural practice.

This study did find some support for researchers who stated that cross-cultural service provision involved a paradigmatic shift in the mind of the therapist (Adams, 2010; Bingham et al., 2002). However, the findings presented suggest that the shift is geared more towards the way practitioners view service provision, and interpretation of outcomes and adherence, rather than becoming aware of their own cultural values and their values' impact on therapy.

The results from this study suggested that CALD clients were reportedly just as likely to actively engage in therapy as mainstream clients, however, outcomes needed to be considered within the constraints of culturally dictated factors. In some cases, clients were after short-term expert advice to gain assistance to rectify a situation, rather than seeking long-term therapeutic contact; in such cases, it is important to not consider a termination of therapy as a failure (i.e., clients have received what they needed). This finding reinforces the view that cross-cultural work requires a paradigmatic shift.

Limitations and Future Directions

A caveat of this study is the possibility of sampling bias due to the voluntary nature of recruitment. Only a minority of participants discussed negative experiences with CALD clients, indicating the possibility that participants may have responded in a socially desirable style. It is possible that participants may have been intentionally or unintentionally presenting their abilities and experiences in a more positive light than was merited. It is also possible that participants were not subjectively aware of their own limitations as multicultural practitioners. Moreover, there were no objective measures to gauge the effectiveness of the approaches discussed.

Future studies would benefit from a mixed method approach, where the qualitative approach is complimented by objective measures of therapist efficacy. Additionally, future research should examine CALD clients' perspectives on what is important and effective in multicultural counselling.

Conclusion

Whilst the current study is not free of limitations, it is the first of its kind to explore mental health practices with CALD clients. The findings contribute to the literature by identifying tangible practices reflecting key concepts of cultural competence, thereby

narrowing the void between theory and practice. Future research directions in the field of cross-cultural service provision are also highlighted.

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