Immigrant Perspectives on Multicultural Competencies of Clinicians: A qualitative study with immigrants in Portugal

Abstract

The recognition of the importance of addressing cultural issues in psychotherapy and counseling has been increasing. The present paper seeks to contribute to the specification of multicultural competencies in the fields of counseling and clinical psychology, based on clients' perspectives. In particular, its objectives were (1) to explore the experiences of individuals of ethnic minority groups regarding their access to the Portuguese healthcare system and (2) to identify the multicultural competencies of the clinicians (as perceived by the clients) which would be required to improve culturally sensitive treatments. The sample included 40 adults from different ethnic minority groups in Portugal - a total of 30 women and 10 men - with a mean age of 34. Participants took part in one of eight focus groups, which were conducted using a semi-structured interview plan. Content analysis revealed that, generally, participants had experienced discrimination in the healthcare system, and that mental health care was perceived as mixed (both positive and negative). Furthermore, participants identified specific aspects of multicultural awareness, knowledge, and skills required of clinicians to provide culturally sensitive treatments, providing support **for** the tridimensional model of multicultural competencies. Implications are discussed for ethical guidelines and clinical training.

Keywords: cultural sensitivity; counseling; minority ethnic clients; patient centered care; qualitative methodologies.

Introduction

The recognition of the importance of attending to cultural issues in psychotherapy and counseling has been increasing, along with the diversity of most societies and clients seeking help in mental health services. Despite ongoing debates regarding the relevance of the cultural responsiveness of treatments and the processes of development of multicultural competencies (Arredondo & Perez, 2006), clinicians seem to recognize the need to be able to work with individuals different from themselves regarding values and behaviors based on ethnic origin, race, religion, language, age, gender, sexual orientation and (dis)ability (Daniel et al., 2004). All these differences influence the healthcare provider-receiver interaction.

According to the International Organization for Migration (IOM; 2009), global trends show a significant increase in the number of immigrants over the past 10 years, specifically referring to the flow of people into more developed nations - from an estimated 150 million in 2000 to 214 million in 2010. In Europe, the percentage of immigrants was estimated at 8.9% in 2005, compared to just 3.4% in 1960. In Portugal, for example, the number of immigrants has increased significantly in the last two decades. In fact, recent official Portuguese reports indicate that there was a 200% rise in the immigrant population since the 1990s in Portugal (Machado et al., 2010), with growing concerns regarding the social integration and development of new approaches to migrant health in general and mental health in particular. Cultural competence of clinicians and health services plays a central role in healthcare, since culturally diverse groups comprise the largest growing segment of the patient population (Anand & Lahiri, 2009). However, the IOM (2009) concluded that most healthcare systems in European countries do not ensure just, equal, and culturally appropriate treatment of the increasing number of migrants and ethnic minority patients who make use of them.

Originally conceptualized as cultural sensitivity or responsiveness (Sue, Zane, Nagayama & Beger, 2009), definitions and perspectives on the meaning of cultural

competence vary (Fields, 2010). Nonetheless, taken globally, they imply that practitioners in clinical settings and psychotherapy or other mental health services are able to demonstrate their ability to perform adequate and quality care to culturally diverse clients. As such, cultural competence has been defined as a dynamic and complex process of being aware of and recognizing individual and cultural differences, which are reflected in a practitioner's attitudes and beliefs, knowledge, and skills in working with individuals from a variety of cultural groups (e.g. racial, ethnic, gender, social class, sexual orientation) (Constantine & Ladany, 2001).

More than three decades ago, Sue (1977) identified disparities in the utilization of community mental health services among ethnic/racial minorities in the US. Although certain conditions surrounding migration processes may increase vulnerability and minority groups may be exposed to a higher number of risk factors for mental and physical health (related to legal status, access to health services, discrimination, social exclusion, cultural and language differences) (Bhugra et al., 2011), there are still major disparities in the mental health treatments available to them (Alegria et al., 2010; Mielck & Giraldes, 1994). While the need for culturally competent mental health care has been widely acknowledged, disparities still remain and the increasing socio-demographic shift toward greater cultural diversity in population necessitate further changes in the healthcare system (Whaley & Davis, 2007).

The sources of disparities in healthcare are complex and exist in a broader historical and contemporary context of social and economic inequality, prejudice, and systematic bias (Sue et al., 2009). There is evidence of stereotyping and bias even among healthcare providers (Van Ryn & Burke, 2000; Moleiro et al., 2009). Furthermore, the healthcare system itself can be less in accordance with cultural perspectives of some clients than others (Johnson et al., 2004). Also, health and illness related representations can vary across cultures, as can the manifestations of disorders, diseases, and healing, and the expectations and assumptions about

a clinician's capabilities (Alegria et al., 2010).

As was previously mentioned, initial appeals for cultural competency grew out of concerns for the status of ethnic minority group populations in the United States (e.g. African Americans, American Indians and Alaska Natives, Hispanics and Asian Americans; Sue et al., 2009). The documented evidence revealed that mental health services were not equally available, accessible, and effectively distributed for different ethnic and racial groups, which were found to underutilize it or to prematurely terminate treatment, when compared to White Americans (Alegria et al., 2010; Sue, 1998). Whaley and Davis (2007) referred to this as an example of unmet needs. Currently, multiculturalism and the importance of cross-cultural counseling competence are widely recognized on an ideological basis and are presumed to be significant factors in effective counseling services.

Among the theoretical approaches developed to describe cultural diversity competencies, a seminal work was introduced by Sue et al. (1992) - the model of multicultural competencies. Since its publication, the original model has undergone several revisions and has been incorporated into the graduate training of most psychology counseling programs in the US. The model (see Sue, 1998) describes three-dimensions of cultural competence, namely, the possession of awareness, knowledge, and skills of a particular culture to an extent that allows the delivery of effective services to such a population. The first dimension--racial and cultural awareness--includes the practitioner's own understanding of racially or culturally based beliefs and attitudes about themselves and others. The second dimension is centered on how clinicians understand their clients' worldviews, cultural dispositions, racial identity development and sociopolitical pressures, and how these affect case conceptualization and treatment planning. The third dimension focuses on the ability to use intervention strategies, which are sensitive to cultural and contextual factors of the client, such as a client's spiritual beliefs, socioeconomic resources, and cultural traditions (Sue, 1998).

The American Psychological Association (APA, 1993; 2003) is among the professional organizations that have created guidelines outlining cultural competencies. The Association for Multicultural Counseling and Development (AMCD) is another organization that has produced such guidelines (Arredondo & Perez, 1996; Sue et al., 1992). Contrary to its North American counterparts, most European professional associations have made little progress in establishing much needed guidelines and standards of care, practice, and training.

Despite the noted developments on the topic of cultural diversity competence, an important phase of remaining work involves the empirical examination of how these competencies work in counseling and psychotherapy. An empirical examination may help practitioners better understand the manner and extent to which the competence facilitate multicultural counseling and may also lead to further theoretical and empirical developments in this area (Fuertes & Brobst, 2002). Attempts at identifying effective ways of assessing multicultural competence have been argued to be especially significant (Constantine, 2002). Although the focus of the vast majority of such research is based on self-report measures, client perception is becoming increasingly recognized as valuable and important. Several studies (e.g. Constantine, 2002; Pope-Davis, Coleman, Liu & Toporek, 2003; Moleiro, Marques & Pacheco, 2011) have found little correlation between self-reporting and another's ratings of multicultural competencies. Such findings show the need to assess the clinician's multicultural competence through client perception of these competencies. After all, client perspective may be the source of useful information about different aspects of counseling regarding multicultural issues (Minas, 2007). Moreover, client satisfaction with treatment is an important variable, since satisfied clients are more likely to adhere to a treatment process and have better treatment outcomes (Dutta-Bergman, 2005).

Despite the under-representation of studies, which take client reports into account, some research has been conducted thus far. Fuertes and Brobst (2002) focused on client

perception of the counselor's multicultural competencies and have found that they strongly correlate with a counselor's attractiveness, trustworthiness, expertise, and perceived empathy. Research also examined differences in perceptions between Euro-American and ethnic minority respondents; when comparisons of client satisfaction were made, a counselor's multicultural competence explained a large and significant amount of the variance for the ethnic minority participants only.

Results of a study by Cook and colleagues (2005), in which they assessed satisfaction of minority community members in Omaha (seventy-two members, representing African Americans, Hispanic Americans, Native Americans, Sudanese, Vietnamese, and eight European Americans) showed that the majority of respondents were satisfied with the care they received. Perceived cultural competency was not associated with satisfaction, although, for a small number of participants, language, communication, and culture contributed to dissatisfaction. In addition, some respondents indicated their preference for a healthcare provider similar to themselves in terms of racial, ethnic and/or cultural background, and/or thought that some conditions were better treated by a provider of the same racial, ethnic and/or cultural background.

While sensitive and flexible treatment is relevant to all groups of clients, some evidence suggests that racial and ethnic minority clients are more likely to perceive bias and lack of cultural competence when seeking treatment in healthcare systems (Johnson et al., 2004). Yet, not many research studies have explored the racial and ethnic minority client's perceived satisfaction with mental health services or their attitudes toward counseling in relation to satisfaction with it (Constantine, 2002). Also, it is important to point out the scarcity of studies of culturally specific aspects of clinical interventions in non-anglo-saxon environments.

Health and social care providers in Portugal and other European countries are

currently more likely to meet diverse clients, culturally different from themselves. For this reason, the development of cultural diversity competence for clinicians is of great importance. Client perspective is, in this case, an indispensable source of information, which may serve to better understand the relevant factors in establishing an intercultural helping relationship, culturally sensitive assessment, and course of treatment. The purpose of the present study is, therefore, to contribute to a definition of cultural diversity competence from the perspective of immigrant clients and to encourage further research in the field, especially focusing on clients and their perspectives.

Methods

The main purpose of this study was to contribute to the increase of interest in the field of multicultural competence studies within Europe, and, in particular, within Portuguese society. It also aimed at encouraging the development of guidelines and standards of care with the objective of promoting culturally competent and effective interventions for minority groups present in Portugal, in this particular case, to ethnic minority groups. Its specific objectives were to explore the perceptions and experiences of individuals of ethnic minority groups regarding their access to the Portuguese healthcare system, both physical and psychological. It also strove to characterize the specific needs and obstacles this population encounters in their interactions with mental health professionals.

Participants

The present study included the participation of 40 adults from different ethnic minority groups in Portugal - a total of 30 women and 10 men - with a mean age of 34.4 (median = 34; sd = 12.3). The majority of participants (71%) were between the ages of 18 and 39, and 8% ranged age 50 and above. The participants were mainly from African countries (a total of 68%), 20% from Brazil, and 12% from other European countries (Ukraine and Switzerland). Participants of African-descent identified themselves as being mostly New Guineans (23%),

Cape Verdeans (18%), and Mozambicans (15%). While ethnic subgroups were not pre-selected, these nationalities are representative of the largest immigrant groups in Portugal, according to the national census (i.e. Instituto Nacional de Estatística), which are composed of Eastern European, Brazilian and African-descent populations. The total number of years living in Portugal ranged from a minimum of 5 months to a maximum of 30 years, with a mean time of 10 years. In terms of nationality, 80% of the participants maintained their nationality of origin and 20% reported having acquired Portuguese citizenship. The participants of this study were composed of 38% unemployed people, 20% employed individuals and 43% students (of which 7% studied and worked at same time). More than 60% of the participants had an educational level equal to or higher than high school, 43% of which were attending college. Four participants were illiterate. It should be noted that the sample age distribution, comprised of mostly young adults, was partly a result of the sampling procedures, which included student immigrants: studying in Portugal constitutes an important reason for immigration to Portugal, mainly from African countries and Brazil.

With regards to migration history, 75% of the participants reported never having been in another country before Portugal. Even though the reasons for coming to Portugal were varied (academic, family reunion, economic, health, or political), a large number of participants came to Portugal to study in college or for economic reasons.

Finally, when asked about their experiences with Portuguese mental health services, 85% of the participants reported having no previous counseling or psychotherapy experience. For those who had some experience, the main clinical issues included depressive symptoms and grief. The demographic information of participants is summarized in Table 1.

Insert Table 1

Instruments and Procedures

The study utilized a qualitative methodological approach, involving the use of eight

focus groups (Krueger & Casey, 2000) conducted in non-clinical settings taking place between March and November of 2010. Participants were recruited from universities (three international student groups) and immigrant associations (five groups) in Lisbon. Groups ranged in size from three to six members each. Since all participants understood and spoke fluent Portuguese, either as their first (i.e. from Brazil) or second language (i.e. from Cape Verde), the use of interpreters or mediators was not required. The focus groups, which lasted around one hour each, were all recorded and transcribed for later analysis.

There were several reasons for choosing a focus group approach to collect the data. In general, focus groups can be a very useful method for collecting data since they provide researchers with direct access to the language and concepts participants use to structure their experiences and to think and talk about a designated topic (Hughes & DuMont, 1993; Thompson, Bazile & Akbar, 2004; Constantine, 2007). Furthermore, they may also provide participants with a psychologically safe environment in which to share and build upon each other's ideas (Whealin & Ruzek, 2008).

Data was collected using a semi-structured interview plan, developed according to the goals of the study and the relevant literature. Focus group questions included the following topics: 1) access and experiences with the Portuguese healthcare system (physical and psychological); 2) provider qualities preferred in working with immigrant clients and 3) the perceptions of the multicultural competencies that are required of psychologists and other healthcare providers (i.e. "*We would like you to make up a list of eight things that mental health professionals, including psychologists, should be aware of or know when working with people from your place of origin.*"). During the focus groups, the interview protocol was not strictly followed, and the interviewers allowed the group to interact without restraint (sometimes in their own first language), addressing other questions and issues without undermining the main theme, with the aim of accomplishing the study goals.

The present study was part of a larger three-year project, which was submitted to and supported by national funding from a government agency (Fundação para a Ciência e Tecnologia; Grant PDCT/PSI/71893/2006), having been previously approved by the university research center. All participants were informed of the study's objectives, its confidentiality, and the anonymous and volunteer nature of participation. Consent also included the permission to audio-record the group interview. Prior to participation in the group, each participant signed an informed consent sheet and completed a form regarding their demographic information.

Data analysis

The interviews were transcribed and analyzed by the research team and the data collected was subjected to content analysis (Bauer, 2000). The approach utilized a blended model, incorporating features of Thematic Content Analysis (see Morant, 2006) and Consensual Qualitative Research (Hill et al., 1997; 2005) since they most adequately fit the goals and methodology of the study. Initial content domains were established based on a three-dimensional model of the conceptualization of multicultural competencies, while also allowing unanticipated themes in the data to shape the analysis and categories. Hence, the approach to the data analysis involved three central aspects: domains, categories (and subcategories), and frequency (categorizing codes as "*General*" if they were present in all cases, "*Typical*" if present in at least half of the cases and "*Variant*" if present in fewer than half of the cases, according to Hill et al. (1997; 2005). Thus, initially the data were grouped into the domains *knowledge*, *awareness*, and *skills*. Subsequently, categories and sub-categories were generated using open coding. Similar methodologies have been used and reported in other research studies on multicultural competence and ethnic studies (Neufeldt et al., 2006; Moleiro et al., 2009).

Results

The process of coding and comparison of categories was conducted separately for exploring (i) the access to and experiences in the Portuguese healthcare system and (ii) the perceptions of multicultural competencies required of clinicians. A summary of categories and frequencies is presented in Table 2.

Insert Table 2

Regarding the participants' reported access to and experiences with the Portuguese Mental Healthcare System (PMHCS), the results indicated that the majority (85%) had had no experience in the PMHCS. However, for those who had had some experience, the main reasons for seeking help were for depressive symptoms (such as sadness, hopelessness and helplessness), and sleep problems, as follows:

"*I noticed that every winter I felt extremely sad (…); it is a problem I have, maybe seasonal depression or something like that, so I needed to go to the doctor. Then I went to a psychologist at a healthcare center.*"

Participants reported having mixed experiences with the healthcare services: from positive experiences, in which professionals paid adequate attention to cultural differences to less positive ones, such as difficulties with the language, disappointment with the services provided, and differences between public and private practice, as reported bellow:

"*And then I went to a psychiatrist, in a private practice… and it was amazing! It was the opposite of the first psychiatrist… in addition to paying attention to my current situation, she was also concerned with my situation here as an immigrant.*"

"*… and the experience I had here with doctors and health professionals was quite diverse ... at first I noticed there was a huge barrier because of my Portuguese accent.*"

"*My Mom, since she arrived, has had and still has some serious integration problems, and she has been suffering from depression; and with all of the mental health professionals*

who have worked with her, the only treatment they have given her has always been based on drugs. It's something we argue about, because I think that's not how these kinds of problems are solved."

Furthermore, some participants mentioned the existence of other types of help-seeking behaviors and professionals, such as traditional healers, within the immigrant population:

"*I think that a person who chooses to go to a traditional healer in his or her country of origin won't seek a psychologist here. I think they'll probably look for the same kind of resources here...*"

Related to participants' perception of counselors' or clinicians' multicultural competencies when working with immigrants and ethnically diverse clients, the main results and illustrative excerpts are presented in Table 3.

Insert Table 3

As illustrated in Table 3, the three domains or main categories – awareness, knowledge and skills – gave rise to 21 subcategories: 7 subcategories in issues related to clinician awareness, 8 referring to cultural knowledge, and 6 in regards to specific clinical skills. The identified elements of awareness ranged from respect and self-awareness of biases, stereotypes and reactions, to aspects related to the differences of language as well as spiritual and cultural background in the therapeutic relationship. Very specific subcategories of knowledge were also identified by participants: i) cultural knowledge about specific groups, family structures and communities; ii) understanding of acculturation processes and discrimination practices; iii) comprehension about the effects of migration on development, personality, psychopathology; iv) and information on larger sociopolitical factors and institutional barriers. Lastly, skills were recognized in a wide range of practical aspects of assessment and intervention, both within the clinical relationship and also outside of it (in

consultation, cultural mediation, translation, training/education and at an organizational/societal level).

Participants often described psychologists and other mental health providers as professionals able to help in several areas beyond mental health, including administrative tasks (such as serving as liaison with social security), a mediation role within society and at an organizational level. However, while they recognized these roles, they also pointed out the financial difficulties they encounter when seeking professional help, as reported in the examples below:

"*The other day I was with my psychologist and she asked me to bring along all my children's and my own documents, and she helped me fill out the forms so I could get minimum income.*"

"*I paid for a psychologist for my daughter, but I have a lot of financial problems because I also have to buy medication and pay for medical exams*."

Participants agreed that professionals are presently more aware of their own difficulties and limitations when working with diverse clients, and suggested the need for further sensitivity and knowledge when working with immigrants and ethnically diverse groups through continuous education and training.

Discussion

The present paper aimed to contribute to the specification of multicultural competencies in the field of clinical psychology in Portugal. In particular, its objectives were (1) to explore the experiences of individuals of ethnic minority groups regarding their access to the Portuguese healthcare system, both physical and psychological, and (2) to identify the multicultural competencies of clinicians (as perceived by the clients) which would be required to improve culturally sensitive treatments.

The results of our study revealed that all participants had undergone prior

discriminatory experiences within the healthcare system. While most report an infrequent use of mental health care, for almost half, the experiences in such care were mixed, being both positive and negative. Some alternative treatments are, hence, sought. A perceived lack of cultural sensitivity seems to continue to be a barrier, involving frequent experiences of discrimination in health care. As highlighted by previous authors (American Institutes for Research, 2002, cited in Anand & Lahiri, 2009), "social issues such as stereotyping, institutionalized racism, and dominant-group privilege are as real in the examining room as they are in society at large" (p. 390). Therefore, the results call attention to the still insufficient consideration of the fact that cultural diversity among patient populations is a growing reality and that this requires adequate culturally-sensitive policies at both a national and European level, as has been the case in the US and other countries (Anand & Lahiri, 2009), particularly in the realm of clinical training (IOM, 2009).

In fact, the results reveal a salient paradox: even though participants recognize and value the role of counselors and other clinicians as a resource for coping with distress, they also realize that few health professionals have the systematic training, knowledge, and skills in multicultural issues and defend that further education and training in this area is needed. This finding is consistent with those found by other authors regarding the expectations and help-seeking behaviors of ethnic minorities and migrants (Moleiro et al., 2009). This paradox may be a risk factor for early drop-out from treatment, which is of particular concern among ethnic minority group members, given their increased exposure to minority stress and experiences of prejudice and discrimination (Sue et al., 2009; Van Ryn & Burke, 2000). While there has been increasing research devoted to establishing guidelines for empirical support for specific treatments' effectiveness since the mid 1990s, relatively few studies have involved the test of interventions with ethnic minority populations (Wong, Kim, Zane, et al., 2003). Our findings, however, point to the need for the development of this line of research,

as well as the dissemination of those studies to service providers.

Presently, considerable literature has relied on client–provider ethnic matches as an attempt to provide culturally sensitive interventions, assuming that a match will occur on numerous underlying cultural aspects (e.g., values, cultural identity, mental health beliefs) between client and provider. However, it has been shown that providers of an ethnic minority background are not necessarily more culturally competent than majority providers (e.g. Neufeldt et al., 2006). Furthermore, Wong and colleagues have empirically demonstrated that matching is unwarranted, and proposed that ethnic group analyses give way to the examination of specific culturally based variables, such as treatment credibility, treatment expectations, value orientation, and cultural identity (Wong, Kim, Zane, et al., 2003). Their call is not only to investigate whether a treatment is empirically effective/ineffective with a particular ethnic group, but also to assess the specific psychological processes that are linked to treatment outcomes.

Our results further support the need for the development of both national and European guidelines to help systematize the competencies necessary for working with migrants and ethnic minorities (Bhugra et al., 2011). Our findings also suggest that client experience and perspective can be a rich source of information for identifying the preferred qualities of a healthcare provider (Minas, 2007), arguing for the involvement of service users in healthcare planning and delivery.

Our findings suggest that client-identified competencies may fit the three-dimensional model of individual and cultural diversity competencies – awareness, knowledge, and skills – posited by previous literature (Sue et al., 1992). In fact, multicultural awareness of clinicians was emphasized, defined as: being comfortable with cultural differences; being aware of the client's background and its influence on psychological processes; being aware of one's own stereotypes and negative emotional reactions towards groups and clients; respecting

indigenous helping practices and community networks; respecting a client's religious and spiritual beliefs; and valuing multilingualism. Specific knowledge of cultural issues was also described by participants, including knowledge about certain groups and their culture, minority family structures and communities, and culture-bound and linguistic features of the provision of psychological care. In addition, according to our participants, mental health professionals should know about: acculturation processes; prejudice and racism; how race and ethnicity impact personality formation and manifestations of distress; the role of sociopolitical variables, immigration, poverty, and powerlessness; and to know how to recognize institutional barriers to mental health care. Finally, a number of multicultural skills were listed, such as: identifying the signs and symptoms associated with immigrant status; incorporating cultural aspects into assessment and intervention; working toward eliminating bias, prejudice, and discrimination in their own workplace; taking responsibility for providing linguistically appropriate care; seeking continuous education and training, as well as consultation and supervision; and advocating for clients at an institutional level.

This variety of subcategories also underscores the importance of moving beyond the more commonly accepted three basic domains proposed by the model of Sue et al. (1992). In fact, various conceptual models of multicultural competencies have been recently developed, and they can be organized into five major groups (Spitzberg & Changnon, 2009). The first group encompasses the component models, which aim to identify the dimensions or factors that constitute this competence (in which we can include the model by Sue and colleagues, 1992). A second group of conceptual models (designated co-orientation models) proposes the inclusion of interaction processes between the different dimensions. A third group involves models of adaptation (where adaptation to the context in itself constitutes a criterion of competence, as in the example of acculturation process models). Finally, explanatory causal models and developmental models have been presented. The causal models focus on the

attempt to trace or outline a linear causal explanation, considering multiple variables and possible processes of moderation and mediation, while developmental models explicitly recognize that clinical multicultural competencies develops over time, postulating stages of its development (Spitzberg & Changnon, 2009). Thus, several models have been proposed for the concept of multicultural competencies and, as a whole, they stress its complexity.

While we recognize the value of the contributions of this study, we also acknowledge some of its limitations, in particular relating to the small size of the sample and its non-representativeness. Furthermore, qualitative analysis was conducted by the authors rather than by independent raters or judges.

Conclusion

Notwithstanding, and in conclusion, this paper defends the fundamental role of multicultural competencies of clinicians when working with immigrants and ethnic minority clients. It highlights that European guidelines for immigrant and ethnic minority care and for clinical training are lacking, and that an important barrier in the access of quality mental health care is perceived scarcity of cultural sensitivity, which even involves experiences of discrimination in the health care.

References

Alegria, M., Atkins, M., Farmer, E., Slaton, E., & Stelk, W. (2010). One Size Does Not Fit All: Taking Diversity, Culture and Context Seriously. *Administration and Policy in Mental Health and Mental Health Services Research,* 37(1-2), 48-60.

Anand, R. & Lahiri, I. (2009). Intercultural competence in the health care – Developing skills for interculturally competent care. In D.K. Deardorff (Ed.), *The SAGE Handbook of Intercultural Competence* (pp. 387-402). Thousand Oaks, CA: SAGE.

American Psychological Association (1993). Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. *American Psychologist, 48*(1), 45-48.

American Psychological Association (2003). Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. *American Psychologist, 58*(5), 377-402.

Arredondo, P. & Perez, P. (2006). Historical Perspectives on the Multicultural Guidelines and Contemporary Applications. *Professional Psychology: Research and Practice, 37(1),* 1-5.

Bauer, M. (2000). Classic content analysis: A review. In M. Bauer & G. Gaskell (Eds.), *Qualitative researching with text, image and sound: A practical handbook* (pp.131- 151). London: Sage Publications.

Bhugra, D., Gupta, S., Bhui, K., Craig, T., Dogra, N., Ingleby, D., Kirkbride, J., Moussaoui, D., Nazroo, J., Qureshi, A., Stompe, T. & Tribe, R. (2011). WPA guidance on mental health and mental health care in migrants. *World Psychiatry,* 10, 2-10.

Constantine, M. G. (2002). Predictors of Satisfaction with Counseling: Racial and Ethnic Minority Clients' Attitudes Toward Counseling and Ratings of Their Counselors' General and Multicultural Counseling Competence. *Journal of Counseling Psychology, 49(2),* 255-263.

Constantine, M. G. (2007). Racial micro aggressions against African American clients in cross-racial counselling relationships. *Journal of Counseling Psychology*, 54(1), 1–16.

Constantine, M.G. & Ladany, N. (2001). New visions for defining and assessing multicultural counseling competence. In J.G. Ponterotto, J.M. Casas, L.A. Suzuki, & C.M. Alexander (Eds.). *Handbook of multicultural counseling*. (2nd ed.) Thousand Oaks, CA: Sage.

Cook, C. T., Kosoko-Lasaki, O. & O'Brien, R. (2005). Satisfaction with and Perceived Cultural Competency of Healthcare Providers: The Minority Experience. *Journal of the National Medical Association, 8 (97)*, 1078-1087.

Daniel, J.H, Roysircar, G., Abeles, N. & Boyd, C. (2004). Individual and cultural-diversity competency: Focus on the therapist. *Journal of Clinical Psychology, 60(7*), 755 – 770.

Dutta-Bergman, M. J. (2005). The relation between health-orientation, provider-patient communication, and satisfaction: an individual-difference approach. *Health Communication, 18(3)*, 291-303.

Fields, A. J. (2010). Multicultural Research and Practice: Theoretical Issues and Maximizing Cultural Exchange. *Professional Psychology: Research and Practice, 41(3)*, 196-201.

Fuertes, N. J. & Brobst, K. (2002). Clients' Ratings of Counselor Multicultural Competency. *Cultural Diversity and Ethnic Minority Psychology, 8(3)*, 214–223.

Hill, C., Knox, S., Thompson, B.J., Williams, E.N., Hess, S.A. & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52(2*), 196–205.

Hill, C.E., Thompson, B.J. & Williams, E.N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25,* 517-572.

Hughes, D. & DuMont, K. (1993). Using focus groups to facilitate culturally anchored research. *American Journal of Community Psychology*, 21, 775-806.

International Organization for Migration (2009). *Developing a Public Health Workforce to Address Migrant Health Needs in Europe.* Brussels: IOM.

Johnson, R. L., Saha, S., Arbelaez, J. J., Beach, M. C. & Cooper, L. A. (2004). Racial and Ethnic Differences in Patient Perceptions of Bias and Cultural Competence in Health Care. *Journal of General Internal Medicine, 19(2),* 101-110.

Krueger, R., & Casey, M. (2000). *Focus Groups: A Practical Guide for Applied Research* (3rd ed.). CA, USA: Sage Publications.

Machado, M. C., Pereira, F. & Machaqueiro, S. (2010). Approaches to migrant health in Portugal. *Eurohealth, 16*(1), 30-31.

Mielck, A. & Giraldes, M.R. (1994). *Health Inequalities: Discussion in Western European Countries* (Eds.). New York: Waxmann Munster.

Minas, H. (2007). Developing mental-health services for multicultural societies. In: D. Bhugra & K. Bhui (Eds), *Textbook of Cultural Psychiatry*. Cambridge, UK: Cambridge University Press.

Moleiro, C., Marques, S & Pacheco, P. (2011). Cultural Diversity Competencies in Child and Youth Care Services in Portugal: Development of two measures and a brief training program. *Children and Youth Services Review, 33(5),* 767-773.

Moleiro, C., Silva, A., Rodrigues, R. & Borges, V. (2009). Health and Mental Health needs and experiences of minority clients in Portugal. *International Journal of Migration, Health and Social Care, 5*(1), 15-24.

Morant, N. (2006). Social representations and professional knowledge: the representation of mental illness among mental health practitioners. *British Journal of Social Psychology, 45*, 817-838.

Neufeldt, S. A., Pinteris, E. J., Moleiro, C., Lee, T. E., Yang, P. H., Brodie, R. E., & Orliss, M. J. (2006). How do graduate student therapists incorporate diversity factors in case conceptualization? *Psychotherapy: Theory, Research, Practice, Training (Special issue: Culture, Race, and Ethnicity in Psychotherapy), 43*(4), 464-479.

Pope-Davis, D.B., Coleman, H.L.K., Liu, W.M., & Toporek, R.L. (2003). *Handbook of Multicultural Competencies in Counseling and Psychology.* London: Sage.

Spitzberg, B. H., & Changnon, G. (2009). Conceptualizing intercultural competence. In Deardorff D. K. (Ed.), *The SAGE Handbook of Intercultural Competence* (pp. 2-52). Thousand Oaks, CA: Sage.

Sue, D.W., Arredondo, P.A. & Davis, R.J. (1992). Multicultural counseling competencies and standards: A Call to the profession. *Journal of Multicultural Counseling and Development*, *20*, 64-88.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32,* 616–624.

Sue, S. (1998). In Search of Cultural Competence in Psychotherapy and Counseling. *American Psychologist, 53(4),* 440-448.

Sue, S., Zane, N., Nagayama Hall, G.C. & Berger, L.K. (2009). The Case for Cultural Competency in Psychotherapeutic Interventions. *The Annual Review of Psychology, 60,* 525-548.

Thompson, V. L. S., Bazile, A. & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*, 35 (1), 19–26.

Van Ryn, M. & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science & Medicine*, *50*(6), 813-828.

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence based practice in mental health services: A complementary perspective. *American Psychologist, 62,* 563–574.

Whealin, J. M. & Ruzek, J. (2008). Program evaluation for organizational cultural competence in mental health practices. *Professional Psychology: Research and Practice*, 39 (3), 320–328.

Wong, E., Kim, B.S.K., Zane, N.W.S., Kim, I.J., & Huang, J.S. (2003). Examining Culturally Based Variables Associated With Ethnicity: Influences on Credibility Perceptions of Empirically Supported Interventions. *Cultural Diversity and Ethnic Minority Psychology, 9*(1), 88–96.

Table 1 - Demographic Characterization of the Sample

Demographic characteristics		**Freq.**	**%**
Sex	Male	10	25%
	Female	30	75%
Age (mean)		32	-
Ethnic background	Brazil	8	20%
	Cape Verde	7	18%
	Mozambique	4	10%
	Sao Tome and Principe	6	15%
	Guinea-Bissau	9	23%
	Ukraine	4	10%
	Other	2	5%
Educational level	College graduate	3	8%
	Attending college	17	43%
	High school graduate	4	10%
	Less than high school	12	30%
	None	4	10%
Nº of years in Portugal (mean)		10	-
	< 5 years	13	33%
	6 to 20 years	24	60%
	> 20 years	3	8%

Table 2 - Summary of Categories and Frequencies

Domain and Categories	**General**	**Typical**	**Variant**
Access to and Experiences with the Portuguese Healthcare System			
Infrequent use of Portuguese mental healthcare system		**x**	
Mixed (positive and negative) experiences with the mental health system			**x**
Discriminatory experiences	**x**		
Criticism regarding the type of treatment and intervention provided		**x**	
Search for alternative types of professionals and/or resources		**x**	
Conceptualization of Clinicians' Multicultural Competence			
Awareness of immigration and acculturation processes	**x**		
Awareness of own limitations and difficulties when working with immigrants		**x**	
Acquisition of knowledge and understanding that goes beyond the theory	**x**		
Need to adapt intervention and treatment to the cultural contexts			**x**
Ability to work with other professionals			**x**

Table 3 - Components of Cultural Competence

AWARENESS	KNOWLEDGE	SKILL
1. Respects indigenous helping practices and community networks. "*I think it's very important to take into account the type of medicine used by some people because in many places people use a lot of traditional medicine in both physical and mental health*." **2. In touch with emotional reactions toward racial/ethnic groups and being non-judgmental.** "*I suppose that a professional in psychology should not judge anyone for whatever reason*." "*And sometimes they mistreat doctors and people who are there* [in the hospital]. *But there are also doctors who are discriminatory.*" **3. Aware of the other's background or experiences and biases and how they influence the psychological process.** "*I noticed that the psychiatrist, in addition to paying attention to my experience in general, also tried to understand my situation here as a person who came from abroad*". **4. Comfortable with differences that exist between themselves and others.** *"I think psychologists have to see difference as a good thing, not as a threat or a bad thing."* **5. Aware of stereotypes and preconceived client notions.** *"You can go to a psychologist who is on the defensive. Is he able?*"	**1. Knowledgeable about groups one works or interacts with.** "*Perhaps they should be knowledgeable about the origin of the person in order to find out more about where she comes from, what her habits are, her way of life*." **2. Has knowledge of the acculturation process the client is going through and distinguishes the processes of different ethnic groups one works or interacts with.** "*I think the first thing the psychologist should know is what is going on with the client... and there is no need to actually go to Sao Tome to know the story, but I think if he has had the same experience as other patients who have also felt the same difficulty integrating, it could help a lot with the process*." **3. Knowledgeable about minority family structures, community, and so forth.** *"They should also know what kind of social support network the person has. At least I think it is important. For example, for someone with family here, the situation is different when compared to someone who has no family".* **4. Understands how race/ethnicity affects personality formation, vocational choices, psychological disorders, and so forth.** "*The psychologist must learn more about customs and traditions such as: obligatory or arranged marriage; problems with female initiation, which is called "fanado"; the difference between Catholic and Moslem religions; and taboo subjects such as sexuality*." **5. Knows how discriminatory practices (prejudice and racism) operate at the community level.** "*There was a time when those who came from Africa had no opportunities: neither to have documents nor to work… nothing. The only ones who had opportunities were the Brazilians. They had good jobs and we "Black people" were treated differently*."	**1. Has expertise in cultural aspects of assessment and intervention.** "*They should take into account the context in which a person is saying and interpreting things and what makes him/her think that way. To differently interpret a sort of persecution ideation. So maybe take into consideration the place where the person came from and try to understand how to interpret their behavior.*" **2. Works to eliminate bias, prejudice, and discrimination.** "*That cannot happen* [racial discrimination]. *A mental health professional cannot have this kind of prejudice; They can't take it to work.*" **3. Seeks to work symptoms inherent to the immigrant status.** "*It helps with issues of insecurity and anxiety. Because when an immigrant comes here, he/she has a lot of problems and should be helped to overcome them*." **4. Can take responsibility for providing linguistic competence for clients.** "*Help overcome language difficulties. Because they ask me to speak properly (…) but still I cannot speak well.*" **5. Seeks out educational, consultative, and multicultural training experiences.** "*Today, we live in a multicultural world. If those old doctors did more in terms of education, there would be no need to change today. Change in order to become more open towards these innovations.*"

Table 3 (Cont.): Components of Cultural Competence.

AWARENESS	KNOWLEDGE	SKILL
6. Respects religious and/or spiritual beliefs of others. "*When he deals with patients who are from different races and ethnic groups… he has to be aware of the patient's culture, his habits, and religious practices, whether he's religious or not... only then he can do a better job*." **7. Values multilingualism.** "*People should understand our language, a psychologist should know how to receive a patient and know what's wrong with him/her, talk to him/her, and understand him/her.*"	**6. Knows about socio-political influences, immigration, poverty, powerlessness, and so forth.** *"Then we have health problems, because the psychologist has to know who needs special treatment and housing and help them buy medicine. Then we have social problems that immigrants sometimes go through, such as legalization and financial problems.*" **7. Understands culture-bound, class-bound, and linguistic features of psychological help.** *"Know the society where he lives, where he/she comes from, or where a person lives, listens, understands the person better, understands the culture of that person, knows the economic level of each person, how to work through difficulties, the ability to know how people handle different situations, for example, racism.*" **8. Knows the effects of institutional barriers.** "*My problem has to do with the way they treat me, places to get the documentation (…) I went to the Foreigners and Frontiers Services office and they told me: "You have to speak Portuguese (…) and one shouldn't do that. Because they may have the same problem of speaking our language when they arrive in our country, just like we do*."	**6. Can exercise institutional intervention skills on behalf of clients.** "*The other day I was with a psychologist and she asked me to bring all my and my children's documents, so that she could help me fill out the forms in order to get minimum income."*

Organizational/societal level: *I think that public hospitals should have better conditions for receiving immigrants. For example, those in attendance/admitting should make an effort to understand them.*"