

Measures of Cultural Competence: Examining Hidden Assumptions

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Abstract

Purpose

The authors critically examined the quantitative measures of cultural competence most commonly used in medicine and in the health professions, to identify underlying assumptions about what constitutes competent practice across social and cultural diversity.

Method

A systematic review of approximately 20 years of literature listed in PubMed, the Cumulative Index of Nursing and Allied Health Literature, Social Services Abstracts, and the Educational Resources Information Center identified the most frequently used cultural competence measures, which were then thematically analyzed following a structured analytic guide.

Results

Fifty-four instruments were identified; the 10 most widely used were analyzed closely, identifying six prominent assumptions embedded in the measures. In general, these instruments equate culture with ethnicity and race and conceptualize culture as an attribute possessed by the ethnic or racialized Other. Cultural incompetence is presumed to arise from a lack of exposure to and knowledge of the Other, and also from individual biases, prejudices, and acts of discrimination. Many instruments assume that practitioners are white and Western and that greater confidence and comfort among practitioners signify increased cultural competence.

Conclusions

Existing measures embed highly problematic assumptions about what constitutes cultural competence. They ignore the power relations of social inequality and assume that individual knowledge and self-confidence are sufficient for change. Developing measures that assess cultural humility and/or assess actual practice are needed if educators in the health professions and health professionals are to move forward in efforts to understand, teach, practice, and evaluate cultural competence.

Acad Med. 2007; 82:548–557.

As we educators in the health professions develop and implement cultural competence training, we face the question of how to evaluate these initiatives. This is largely because of present difficulties in measuring *cultural competence*. Unfortunately, the literature provides little guidance. Rather, a recent review of studies evaluating measures used to assess the cultural competence of health professionals after cultural

competence training has documented both a lack of uniformity and a lack of rigor in researchers' choice of such measures.^{1,2} Reporting on diversity training initiatives in medicine and nursing, respectively, two recent studies^{3,4} conclude that further research is needed to identify valid evaluation methods for assessing the cultural competence of participants.

Reviews of existing cultural competence measures only raise further concerns. First, they raise questions about the reliability of these instruments, noting that most of them were developed without patient input^{5,6} and normed on predominantly white, middle-class, highly educated populations.⁷ There is also the concern that widespread reliance on self-ratings leaves existing measures susceptible to social-desirability effects.^{5,8–10} Second, there is the issue of utility. Existing measures may be lengthy and cumbersome⁸ and may not be completely relevant to trainees.^{5,7} Most disconcerting, however, are questions surrounding the validity of existing measures. It has been argued that many instruments oversimplify both culture^{8,11} and cultural competence.^{5,10} Moreover,

whereas many measures are based on the awareness–knowledge–skill model of cultural competence, there is ongoing dispute about the very meaning of and components of cultural competence.^{1,5,6,10,12,13}

Despite decades of research on cultural competence and the development of numerous measures, it seems that we are still far from establishing valid measures to assess how well practitioners and trainees work across social and cultural differences. In this report, we (1) identify the measures of cultural competence most widely used within the health professions, and (2) examine the understandings of cultural competence that these measures embody. We anticipate that our findings will contribute to ongoing debates about the meaning of cultural competence and to the development of valid evaluation methods for the cultural competence training of health professionals.

Method

To meet our objectives, we conducted a systematic review of the health care

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literature to identify (1) general issues related to the measurement of cultural competence, (2) the range of cultural competence evaluation methods, (3) the most widely used cultural competence measures, and (4) various perspectives on the use of these measures. In October 2005, we searched PubMed, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Social Services Abstracts, and the Educational Resources Information Center (ERIC), using key words selected from each database's thesaurus or headings index (e.g., *cultural competence*, *cultural sensitivity*, *transcultural care*, *outcome assessment*, *attitude measures*, *checklists*, *clinical assessment tools*, *questionnaires*, *scales*, *instrument construction*). No specific time span was used to limit the search; most literature was from the 1990s, with some from the 1980s and a few articles from the 1970s. We then compiled the citations, abstracts, and instrumentation notes of all publications pertaining to the evaluation of cultural competence in the health professions. This allowed us to generate a table of evaluation methods, to categorize these evaluation methods, and to note which cultural competence measures were most frequently cited. At this point, we searched the PubMed, CINAHL, Social Services Abstracts and ERIC databases a second time, using instrument names as key words. This allowed us to generate a second table, listing the most prominent cultural competence measures along with corresponding references.

We then gathered all publications specifically relating to (1) general issues in the measurement of cultural competence in health care, and (2) the use of the most frequently cited cultural competence measures. We obtained copies of the instruments themselves by searching the Internet, contacting instrument developers, and ordering instruments as necessary. Each instrument and its supporting literature were reviewed following a set of structured questions that were developed by one of us (Z.K-T.) as a tool for systematic analysis:

- Why and how was this instrument developed?
- What are its psychometric properties?
- What is its present format?

- What domains of cultural competence does it intend to measure or has it been found to measure?
- What concerns have been raised about this instrument in the literature?
- How does this instrument conceptualize culture and intercultural relations?
- What does it suggest is the problem, and what does it propose or imply is the solution?
- Does this instrument address issues of social power relations, and if so, how?

Having asked these questions about each instrument, we compared our findings across all instruments. This led us to develop an outline of common understandings and assumptions embedded within the measures, which we grouped by theme. We then reviewed the instruments a second time, using our outline as an analytic guide. This allowed us to conduct an analysis structured by assumption rather than by instrument, with notes and examples to illustrate the patterns discerned. In essence, we employed standard iterative qualitative data-analysis techniques, using the texts of the instruments as our data. Close reading of the instruments, guided by critical questions (above), allowed us to interpret the assumptions that seem to underlie what is said and is not said in these instruments. The instruments were critically examined by one of us (Z.K-T.), whose results were reviewed by another (B.B.). Interrater reliability was not measured; rather, consensus was sought.

Results

Range of cultural competence evaluation methods

Our review confirms that there is indeed little uniformity in the methods used to evaluate cultural competence in the training of health professionals. We identified 54 distinct instruments, few cited more than once. In addition, we found a number of studies that used instruments developed specifically for those studies, and a number of articles reporting the use of qualitative or mixed methods to evaluate students' or practitioners' cultural competence (e.g., video or participant observation, student essays, student or practitioner journals, qualitative interviews, open-ended

questionnaires). Evaluation of students' or practitioners' competence was, by far, the most common focus. A small number of articles focused on evaluation of trainers' performance, patient and client perspectives, service outcomes, and organizational competence.

Most prominent cultural competence measures

The most frequently cited evaluation methods are quantitative instruments developed to measure the cultural competence of individual students or practitioners. Information about these instruments is presented in Table 1, with an overview of their development histories, psychometric properties, and present formats. Although several reviews^{5-7,13} suggest that the MCI, the MAKSS-CE-R, the MCAS-B/MCKAS, and the CCCI-R are the most widely used cultural competence measures, this does not seem to be the case. (See the tables for the spelled out names of these measures.) Certainly, these four measures are the most frequently reviewed, perhaps because they are among the first of their kind. Judging from the literature, however, only the MCI continues to enjoy widespread use within the health professions.

Underlying assumptions

In examining the 10 most widely used cultural competence measures, we identified six underlying understandings, or assumptions, about culture and cultural competence. We discuss these below. Also, see Table 2 for a summary of these assumptions and a list of the cultural competence measures in which they are embedded.

Culture is a matter of ethnicity and race.

Although the term *cultural competence* is increasingly used in reference to "a variety of cultural (e.g., racial, ethnic, gender, social class, and sexual orientation) groups,"¹⁰ existing measures seem to conceptualize culture as more or less equivalent to ethnicity and race. In fact, all but two of the measures we reviewed limit their concern exclusively to ethnicity and race. The MAKSS-CE-R and the QDI adopt a somewhat broader concern for diversity, although both predominantly focus on ethnic and racial differences. Of the 33 items composing the MAKSS-CE-R, a total of seven items query respondents' "ability to accurately

Table 1
The Ten Most Frequently Cited Cultural Competence Measures*

Cultural competence measure	Development	Psychometric properties	Present format
<i>Multicultural counseling inventory (MCI)</i> ^{35,36} ; cited in 16 studies and six reviews)	<ul style="list-style-type: none"> Based on Sue et al's attitudes–knowledge–skills model of cultural competence First developed in 1994 for use in counseling psychology 	<ul style="list-style-type: none"> Good face and content validity Acceptable criterion validity Unknown test–retest stability Moderate relationship among subscales Four-factor model only accounts for 36% of variance⁷ 	<ul style="list-style-type: none"> 40 items Four-point Likert scale (very inaccurate to very accurate) One general multicultural competency factor and four specific factors: multicultural counseling skills, multicultural awareness, multicultural counseling relationship, and multicultural counseling knowledge
<i>Cultural self-efficacy scale (CSES)</i> ^{37,38} ; cited in 13 studies and one review)	<ul style="list-style-type: none"> First developed in 1987 for use in nursing Revised in 1993 	<ul style="list-style-type: none"> Good reliability and validity¹⁴ 	<ul style="list-style-type: none"> 26 items Five-point Likert scale (very little confidence to quite a lot of confidence) Three sections: knowledge of cultural concepts, knowledge of cultural patterns, and skills in performing transcultural nursing functions
<i>Inventory for assessing the process of cultural competence among health professionals (IAPCC and IAPCC-R)</i> ^{15,39,40} ; cited in 10 studies)	<ul style="list-style-type: none"> Based on Campinha-Bacote's model of cultural competence First developed in 1998 for use in nursing, medicine, and pharmacy Revised in 2003 	<ul style="list-style-type: none"> Good internal consistency and reliability³⁹ 	<ul style="list-style-type: none"> 25 items Four-point Likert scales (very aware to not aware; strongly agree to strongly disagree; very knowledgeable to not knowledgeable; very comfortable to not comfortable; very involved to not involved) Five subscales: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire
<i>Cross-cultural adaptability inventory (CCA)</i> ⁴¹ ; cited in seven studies)	<ul style="list-style-type: none"> First developed in 1987; intended for general use Revised in 1992 	<ul style="list-style-type: none"> Conflicting reports Kelley and Meyers⁴¹ report excellent reliability, face validity, and construct validity; questionable predictive validity Davis and Finney⁴² report four-factor structure not replicable, and cross-cultural adaptability "not measurable by these items and/or this structure" 	<ul style="list-style-type: none"> 50 items Six-point Likert scale (definitely not true to definitely true) Four subscales: emotional resilience, flexibility/openness, perceptual acuity, and personal autonomy
<i>Quick discrimination index (QDI)</i> ²³ ; cited in six studies and two reviews)	<ul style="list-style-type: none"> First developed in 1995 for use in counseling psychology; also intended for general use 	<ul style="list-style-type: none"> Good internal consistency of scale and subscales Stable over 15-week test–retest period Promising face, content, construct- and criterion-related validity²³ 	<ul style="list-style-type: none"> 30 items Five-point Likert scale (strongly disagree to strongly agree) Three subscales: general (cognitive) attitudes about racial diversity, affective attitudes about racial diversity, and general attitudes regarding women's equity issues
<i>Culture attitude scale, or ethnic attitude scale (CAS/ EAS)</i> ^{43,44} ; cited in six studies)	<ul style="list-style-type: none"> First developed in 1979 for use in nursing Revised in 1993 	<ul style="list-style-type: none"> Poor reliability^{45,46} 	<ul style="list-style-type: none"> 20 items for each of the two vignettes (re: Anglo and African American patients; additional vignettes may be added) Five-point Likert scale (strongly agree to strongly disagree) Three factors: Nursing care–patient interaction, cultural health behavior; cultural health attitudes and beliefs
<i>Multicultural awareness, knowledge, and skills survey (MAKSS)</i> ⁴⁷ and <i>MAKSS-CE-R</i> ¹⁶ ; cited in four studies and six reviews)	<ul style="list-style-type: none"> Based on Sue et al's model of cultural competence First developed in 1991 for use in counseling psychology Revised in 2003 	<ul style="list-style-type: none"> Adequate reliability Acceptable support for construct- and criterion-related validity of scale and subscales The MAKSS-CE-R only accounts for one third of the variance that the original MAKSS had accounted for (29.8%)¹⁶ 	<ul style="list-style-type: none"> 33 items Four-point Likert scales (very limited to very aware; very limited to very good; strongly disagree to strongly agree) Three subscales: awareness–revised, knowledge–revised, and skills–revised

(Table continues)

Table 1

(Continued)

Cultural competence measure	Development	Psychometric properties	Present format
<i>Cultural competence self-assessment questionnaire</i> (CCSAQ ⁴⁸ ; cited in four studies and one review)	<ul style="list-style-type: none"> Based on Cross et al's model of cultural competence Originally developed for use in child and adolescent mental health 	<ul style="list-style-type: none"> Acceptable reliability, except for the personal involvement subscale Validity supported by literature and expert review⁴⁸ 	<ul style="list-style-type: none"> Two versions: one for direct service providers, the other for administrators The former consists of 79 items Four-point Likert scales (various) Five subscales: knowledge of community; personal involvement, resources, and linkages; staffing, service delivery, and practice; organizational policies and procedures; and reaching out to communities
<i>Cross-cultural counseling inventory</i> (CCCI and CCCI-R ⁴⁹ ; cited in two studies and nine reviews)	<ul style="list-style-type: none"> Based on Sue et al's model of cultural competence First developed in 1983 for use in counseling psychology Revised in 1991 	<ul style="list-style-type: none"> Questionable test-retest and interrater reliability⁷ Factor structure remains in question^{7,13} 	<ul style="list-style-type: none"> 20 items Six-point Likert scale (strongly disagree to strongly agree), scored by an observer Three factors: cross-cultural counseling skill, sociopolitical awareness, and cultural sensitivity
<i>Multicultural counseling knowledge and awareness scale</i> , formerly the multicultural counseling awareness scale-form B (MCKAS ⁵⁰ ; cited in two studies and seven reviews)	<ul style="list-style-type: none"> Based on Sue et al's model of cultural competence First developed in 1991 in/counseling psychology Revised in 2002 	<ul style="list-style-type: none"> Moderate, convergent validity with MCI Questionable criterion validity Two-factor model only accounts for 32% of variance "Results are preliminary, and the MCKAS should not be used for any individual evaluative purposes"⁵⁰ 	<ul style="list-style-type: none"> 32 items Seven-point Likert scale (not at all true to totally true) Two subscales: knowledge and awareness

* Based on a search of PubMed, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Social Services Abstracts, and Educational Resources Information Center (ERIC), using instrument names as key words. No specific time span was used; articles from the 1990s, 1980s, and 1970s were retrieved. See Table 2 for information about assumptions embedded in these measures.

assess the mental health needs" of men, women, impoverished individuals, lesbians, gay men, older adults, and disabled people; the remaining 26 items focus on "different cultural/racial/ethnic backgrounds." The QDI devotes only 7 of its 30 items to the measurement of sexist attitudes; the remaining 23 items focus on attitudes toward ethnic and racial diversity. It is clear that within these two instruments and across all 10 instruments, culture is primarily understood to be an ethnic and racial phenomenon.

Culture is possessed by the Other; the Other is/has the problem. Most of the measures we reviewed also tend to equate the cultural with the (ethnic and racialized) Other. Dominant groups are seen as not having a culture. Usually, this is reflected in items that present ethnicity and race as concepts that pertain only to minority groups. The MCKAS, for example, includes the following item: "I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups." Certainly, members of

dominant cultural groups also have identities and worldviews that are shaped by culture and racism. Existing measures, however, rarely acknowledge or examine dominant cultures.

Even when these measures do recognize the culture of dominant groups, the result is sometimes the same. The IAPCC-R, for example, expects the competent practitioner to disagree with the following statement: "It is more important to conduct a cultural assessment on ethnically diverse clients than with other clients." An implied message is that some people are "ethnically diverse" and others are not. If the point here were to always explore potential discords between self and patient/client, the item would be more aptly framed in terms of the importance of conducting cultural assessments with clients unlike oneself. Whiteness is understood and presented as the norm, the standard; it is excluded from the concept of cultural diversity. Whereas Whiteness is named in the MCKAS, it is named in a way that suggests that Whiteness is a mere perception of "racial/

ethnic minorities" (e.g., "I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White Establishment"). Race and ethnicity, applied to Whiteness, is depicted as less "real," less a racial or cultural reality, and largely a perception on the part of minority groups.

In a similar fashion, these measures consistently portray ethnocentrism and racism as issues affecting only ethnic and racialized minority groups (groups who have been and are marginalized or subordinated because of ethnicity or race). We should note that most measures actually do little to address ethnocentrism and racism, but when they do, they frequently imply that the problem lies in the disadvantages borne by minority groups—not in the advantages of dominant group membership. This assumption may be found, for example, in items such as, "I am involved in advocacy efforts against institutional barriers in mental health services for minority clients" (MCI), "It upsets (or angers) me that a racial

minority person has never been President of the United States” (QDI), and “Racial and ethnic minorities are underrepresented in clinical and counseling psychology” (MAKSS-CE-R). Although barriers to health care for racialized and ethnic minority groups are well documented (and important for health professionals to be aware of), the point here is that learners are not being assessed as to their understanding of white privilege; learners are only assessed as to their understanding of the effects of ethnocentrism and racism on minorities. These items do not refer to efforts against institutional structures that favor dominant groups, or to anger that the president has always been a white man, or to *over*representation of white, Western European people in the health professions. Even at their best, these instruments focus on disadvantage, constructing a deficit model concerning ethnic and racialized minority groups rather than focusing on privilege and domination.

The problem of cultural incompetence lies in practitioners’ lack of familiarity with the Other. Practitioners should be aware of, knowledgeable about, and seek contact with the Other. At the same time as these cultural competence measures focus on the Other as the problem, they construct the Other as the object of specialized knowledge and then try to quantify the practitioner’s or trainee’s cultural awareness and knowledge. In this way, these measures imply that cultural competence is achieved when practitioners acquire sufficient awareness and knowledge of the Other, often through repeated exposure to the Other. Seven of these 10 measures are either based on the awareness–knowledge–skill model of cultural competence, or they have subscales measuring cultural awareness and/or cultural knowledge. (Intriguingly, the skills associated with cultural competence are often directed at gaining awareness and knowledge—through communication and assessment skills, for example, as opposed to *doing* anything.) Two of these measures, the IAPCC-R and the CCSAQ, have subscales measuring respondents’ exposure to ethnic and racialized minority groups. Other measures have individual items that tap into this notion of exposure, for example, “My life experiences with minority individuals are extensive (e.g., via ethnically integrated neighborhoods,

marriage and friendship)” (MCI) and “My friendship network is very racially mixed” (QDI). Cultural incompetence, then, is assumed to be rooted in practitioners’ lack of familiarity with cultural differences; heightened cultural competence is thought to depend on increased familiarity through increased contact.

Whereas awareness and knowledge of cultural differences are given prominence in these measures, inequitable and oppressive social relations such as ethnocentrism and racism disappear from view. At most, these measures assess practitioners’ *knowledge* about such inequities. The CCCI-R, for example, assesses whether the practitioner “understands the current socio-political system and its impact on the client”—not whether the practitioner has any idea how to work with a client facing those sociopolitical barriers. Although many curricular innovations in cultural competence training address practice skills, the measures being widely used to evaluate learning seem to focus on knowledge alone as the key indicator of culturally competent practice. Without the addition of other more complex measures that assess practices, whether—and how—respondents actually *use* this knowledge in practice is left unexamined. Nineteen of the 26 items on the CSES, and 19 of the 32 items on the MCKAS, evaluate respondents’ knowledge without examining whether and how respondents use that knowledge; this is also true of the knowledge subscales of the MCI, MAKSS-CE-R, MCKAS, CSES, IAPCC-R, and CCSAQ.

Moreover, the criterion validity of the MCI, MAKSS-CE-R, CSES, and IAPCC-R are all supported by studies demonstrating that these measures were indeed able to differentiate between students who received training and those who did not.^{14–21} What these studies prove is that students learned what was taught and that these instruments were able to capture changes in knowledge. Whether students applied what was taught, or whether what was taught had any impact on service processes and outcomes, remains unclear. Practitioners may not know how to use such knowledge, or they may not think or choose to use it in practice, for any number of reasons, possibly including ingrained habits, the expectation to

conform to standard health care procedure, time pressures, lack of confidence, or directives from superiors. Clearly, measuring increased knowledge is not a problem in and of itself; rather, it becomes problematic when measures of knowledge are used as stand-ins for cultural competence, of which knowledge is only one part.

One final point about the assumption that cultural competence rests on increased awareness and knowledge of diverse cultural groups: as we have already remarked, several cultural competence measures imply that contact or communication with diverse individuals leads to increased awareness, knowledge, and overall competence. Items from the CCCI-R illustrate this point: “Counselor elicits a variety of verbal and nonverbal responses from the client” and “Counselor accurately sends and receives a variety of verbal and nonverbal messages.” (Similar items are found in the CSES and the CCSAQ.) Simply speaking with a patient/client who is culturally different from oneself, however, hardly seems to be an indicator of cultural competence. What *kinds* of verbal and nonverbal responses is the practitioner eliciting and sending—are they affirming, empowering responses, or are they marginalizing ones? Similarly, the fact that a student or health professional has had “extensive life experiences with minority individuals” (MCI) tells us little about the *quality* of those experiences. Contact is not necessarily positive, nor does it necessarily foster insight. In fact, a recent study²² found that both the extent of rehabilitation counselors’ multicultural experiences and the percentage of “minority clients” on their caseloads were *inversely* correlated with the quality of their cross-cultural relationships (as measured by the MCI’s multicultural counseling relationship subscale).

The problem of cultural incompetence lies in practitioners’ discriminatory attitudes toward the Other. Here we find the assumption that ethnocentrism and racism are by nature individual failings—individual ignorance (as above) and individual prejudice. At least half of the measures we reviewed include items (and, in some cases, entire subscales) intended to ascertain the presence and degree of discriminatory biases and attitudes. The *awareness* subscale of the

Table 2
Assumptions Embedded in Cultural Competence Measures*

Assumption	Multicultural counseling inventory (MCI)	Cultural self-efficacy scale (CSES)	Inventory for assessing the process of cultural competence (IPACC)	Cross-cultural adaptability inventory (CCAI)	Quick discrimination index (QDI)	Culture attitude scale (CAS), or ethnic attitude scale (EAS)	Multicultural awareness, knowledge, and skills survey (MAKSS)	Cultural competence self-assessment questionnaire (CCSAQ)	Cross-cultural counseling inventory (CCCI)	Multicultural counseling knowledge, awareness scale (MCKAS)
Culture is a matter of ethnicity and race.	✓	✓	(✓)	✓	(✓)	✓	(✓)	✓	✓	✓
Culture is possessed by the Other; the Other is/has the problem.	✓	✓	✓		✓		✓	✓		✓
Cultural incompetence = lack of familiarity with the Other. Seek contact with and about the Other.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cultural incompetence = practitioners' discriminatory attitudes toward the Other.	✓		✓	✓	✓	✓				✓
Cross-cultural health care = Caucasian practitioners working with racialized and "ethnic" patients.	✓			✓	✓			✓	✓	
Cultural competence = being confident in oneself and comfortable with others.	✓	✓	✓	✓	✓		✓	✓		✓

* These assumptions are the authors' interpretations reached after systematic qualitative analysis of each measure as a "text" asking about the implications of what is said and not said, asking how the measure seems to conceptualize culture and intercultural relations, what it focuses on as the problem and/or the solution, and the extent to which it addresses social power relations. The checkmarks within parentheses indicate that the measure incorporates the relevant assumption indicated to some degree, but not to the degree to which some of the other measures do. See Table 1 for descriptions of the measures.

MCKAS, for example, includes items such as “I believe all clients should maintain direct eye contact during counseling” and “I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive”; respondents who indicate agreement with these statements are understood to be demonstrating ethnocentric prejudice. Similarly, the *flexibility/openness* subscale of the CCAI includes items such as “People who know me would describe me as a person who is intolerant of others’ differences,” and “I can enjoy relating to all kinds of people”; these items test for the presence of discriminatory attitudes.

The understanding seems to be that if practitioners would only educate themselves about ethnocentrism and racism and then free themselves of biased worldviews and prejudice, ethnocentrism and racism would no longer be a problem for either practitioner or patient. Some instruments clearly suggest the “correct” attitude is one of comfort with or celebration of diversity (CCCI-R, MCKAS, IAPCC-R, QDI, CCSAQ, MCI, CCAI). The assumption that cultural incompetence is a matter of individual attitudes or discomfort denies the larger structural and systemic realities of racism, ethnocentrism, and other forms of social inequality. Practitioners who have tolerant, nondiscriminatory attitudes will not necessarily be culturally competent if they are not also trained to recognize when actions and inactions that support the status quo and business as usual unintentionally, but systematically, privilege some and marginalize others. Measuring competence must also assess this depth of understanding.

Cross-cultural health care is about Caucasian practitioners working with patients from ethnic and racialized minority groups. Although none of the cultural competence measures reviewed claim to be culture specific (in fact, the QDI and the CCAI are supposedly “culture general,” or valid for use with all cultural groups), many of these measures seem to assume that the respondent is white and that the recipients of care are patients from ethnic and racialized minority groups. One item on the CCCI-R, for example, reads, “Counselor appreciates the client’s status as an ethnic minority.” Presumably, cultural issues

arise only when the client is from an ethnic or racialized minority group. Similarly, items such as, “My life experiences with minority individuals are extensive” (MCI) and “Do you attend cultural or racial group holidays or functions within communities of color?” (CCSAQ) suggest that the respondent is white. How would a practitioner from an ethnic minority group respond to these questions? And what would this tell us about his or her cultural competence?

Many of the measures we examined either assume that both dominant and marginalized groups have the same experiences of multiculturalism, or they take the dominant group’s experience as the norm. For example, one of the factors constituting the QDI is “affective attitudes regarding racial diversity.” Items within this factor include “My friendship network is very racially mixed,” “I think that it is (or would be) important for my children to attend schools that are racially mixed,” and “I would enjoy living in a neighborhood consisting of a racially diverse population.” Items such as these—items that assess one’s enjoyment of multiculturalism, or one’s contact or comfort with diverse groups—do not recognize that white people may be more likely to feel at ease in racially mixed contexts, as they are generally accustomed to feeling at ease in their environments. Thus, some white respondents’ answers to these items may reflect the privileges of being white (e.g., having a sense of belonging and control) rather than the absence of prejudice. Conversely, people from racialized minority groups, who have been systematically disadvantaged and marginalized in white-dominated institutions and communities, may rightfully feel less willing to seek contact with white people and less comfortable when in contact with them. Rather than indicating racial prejudice, some of their responses to the QDI (and other measures) may reflect the disadvantages of being from a racialized minority group (e.g., having to be constantly on guard against racist comments and incidents). This argument is supported by Ponterotto and colleagues²³ finding that, for all factors of the QDI *except* “affective attitudes regarding racial diversity,” African and Latino Americans scored higher than did white Americans.

Cultural competence is about being confident in oneself and comfortable with others. This final finding is related to the one we have just presented. Eight of the 10 cultural competence measures rely to some extent on respondents’ self-ratings of their own confidence or comfort. The entire CSES, for example, is based on a Likert scale of 1 = very little confidence to 5 = quite a lot of confidence. Although other measures use different Likert scale responses, many of their items (e.g., “I am aware of . . .,” “I am skilled at . . .” or “I am comfortable with . . .”) are also ratings of self-confidence and comfort. The implied assumption is that culturally competent practitioners are, above all else, confident in themselves and comfortable with others.

Our review of the literature, however, reveals some evidence to dispute this assumption, suggesting that increased confidence may *not* be a measure of increased competence. To start, small inverse relationships have been found between the *awareness* and *skills* subscales of the MAKSS-CE-R, suggesting that “awareness of differences would lead to acknowledging one’s lack of skills to deal with the cross-cultural barriers.”¹⁶ Similarly, one study suggests that nursing students who receive cultural content in their courses may feel less confident (i.e., score lower on the CSES) than those who receive no cultural course content.²⁴ In another study, investigators examined the effects of an international immersion experience on nursing students’ cultural competence, using both the CSES and student journals to evaluate the program; they found that “students identified themselves as culturally aware and sensitive [on the CSES] prior to their international experiences. However, they did not become aware of how their ethnocentrism affected their ability to become culturally competent providers until they were immersed in another culture.”²⁵ As if to agree with this observation, one of these students noted in a journal entry, “The more you experience another culture and learn, the more you realize what you don’t know about people from other cultures.” Parallel findings exist for the IAPCC-R,^{26,27} suggesting that (1) confidence and comfort may not be valid indicators of cultural competence, and (2) higher levels of confidence and comfort may, in

fact, be indicative of lower insight and awareness.

Conclusions

Earlier, we stated that despite considerable progress, the health professions remain far from establishing compelling and comprehensive methods for measuring competent practice with and across social and cultural diversity. Our findings reveal some of the problematic, unexamined assumptions about cultural competence that are embedded in the most widely used cultural competence measures. We suggest that these assumptions, taken together, constitute a worldview in which culture is perceived as a “confounding variable” that white practitioners must deal with when they interact with people from ethnic and racialized minority groups. Even when concerns beyond race and ethnicity are considered (which is rare), this view of culture “assumes that the locus of normalcy is white, Western culture—that ‘difference’ means nonwhite, non-Western, nonheterosexual, non-English-speaking, and most recently, non-Christian—how they are different from us.”²⁸ From the perspective embedded in these instruments, culturally competent health professionals must prepare themselves for the challenges of multiculturalism, by spending time with “different” groups, becoming more aware and knowledgeable of these groups, and neutralizing their own discriminatory attitudes. The overarching vision is one of confident, competent white health professionals comfortably entering and serving the communities of ethnic and racialized minority groups, armed with specialized knowledge and skills.

If, however, we are to move forward in our efforts to understand, teach, practice, and evaluate cultural competence, we—practitioners, educators, and researchers—need to question and challenge this worldview. We need to explore other perspectives of culture and cultural competence. To start, we might reconsider a definition of culture that encompasses not only ethnicity and race, but also (at least) gender, age, income, education, sexual orientation, ability, and faith. We might also begin to identify and examine the dominant cultures in society, moving “away from a focus on nondominant groups to a study of how

unequal distribution of power allows some groups but not others to acquire and keep resources.”²⁸ This shift in perspective would bring about further shifts—a concern for ethnocentrism, racism, and other forms of oppression, not just as topics to learn about or as personal prejudices to overcome, but as a set of social conditions that both shapes and is shaped by our daily lives. Our new vision of cultural competence might be one of culturally diverse health professionals serving culturally diverse patients, sharing their knowledge while learning from and with patients,²⁹ and bravely acknowledging, recognizing, and challenging the many forms of oppression that produce the enormous disparities in health and well-being we witness today.

Wear²⁸ argues that “what has come to be known in medical education as cultural competency is theoretically truncated and may actually work against what educators hope to achieve.” Echoing this concern, Tervalon and Murray-Garcia²⁹ warn that “in the laudable urgency to implement and evaluate programs that aim to produce cultural competence, one dimension to be avoided is the pitfall of narrowly defining cultural competence in medical training and practice in its traditional sense: an easily demonstrable mastery of a finite body of knowledge, an endpoint evidenced largely by comparative quantitative assessments.” These authors and the findings presented above suggest that we may need to (1) shift and expand what it is that we measure when evaluating cultural competence, (2) measure constructs above and beyond cultural competence in the traditional sense (e.g., racial identity development), (3) develop more theoretically informed measures of effective practice across cultures, and/or (4) explore alternate methods for evaluating cultural competence, namely, qualitative and mixed methods.

Assessing racism rather than contact with members of other racial groups,^{9,22} for example, is one step in the right direction. Broadening still further to assess ethical sensitivity in the context of racial difference,³⁰ and/or to assess notions of critical thinking and civic engagement in the context of racism,²⁶ build on the notion that “difference” is about power-charged social relations, rather than an attribute of the Other

about which one can (and should) acquire knowledge. Further research is needed to examine intersections between cultural competence, ethical sensitivity, critical thinking, civic engagement, and inclinations toward change in practice. We need to know whether such constructs are best measured separately, or whether new instruments can measure an expanded conceptualization of cultural competence.

Similarly, future research might explore the use of qualitative and mixed methods to evaluate new or expanded models of cultural competence. Tervalon and Murray-Garcia²⁹ insist that “capturing the characteristic of cultural humility in individuals and institutions is possible, especially with mixed methodologies that use qualitative methods (including participant observation, key informant interviews, trainees’ journals, and mechanisms for community feedback) and action research models to complement traditional quantitative assessments (pre- and postknowledge tests, patient and trainee surveys) of program effectiveness.” In fact, the use of mixed methods has been widely advocated for some time^{8,10,11,31} and has been implemented by a small, but growing number of researchers. St. Clair and McKenry’s²⁵ use of quantitative (i.e., CSES) and qualitative (i.e., student journals) methods to assess the impact of an international immersion experience is one illustration of the great value of using mixed methods. Qualitative methods alone, however, have also been very effective in evaluating cultural competence; Millstein’s³² study is a striking example of the breadth and depth of qualitative analysis as a method of assessing cultural competence (or “informed consciousness,” in Millstein’s words). Programs engaged in service learning as a means of enhancing cultural competence often employ qualitative assessments to evaluate effectiveness, given that they are emphasizing a wider range of skills and aptitudes beyond the usual knowledge and attitudes.^{33,34} A systematic review of qualitative and mixed methods used to evaluate cultural competence in the health professions would provide much needed guidance, possibly informing development of more appropriate quantitative measures.

In summary, we reiterate our argument that despite considerable progress, the

health professions remain far from establishing valid methods for measuring skilled or competent practice across a wide range of social differences. This study reveals some of the assumptions about cultural competence that are embedded and applied in the most-widely-used cultural competence measures. As practitioners, educators, and researchers, we need to question and challenge these assumptions if we are to move forward in our efforts to understand, teach, practice, and evaluate cultural competence.

Acknowledgments

The authors would like to thank all researchers and instrument developers who generously shared copies of their instruments, or assisted in obtaining them. The authors also gratefully acknowledge funding from the Department of Canadian Heritage, through the Changing Worlds project.

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