The Impact of Culture and Ethnicity in Psychosocial Work

Sonia Cisternas Cid

School of Social Work

McGill University, Montreal

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Abstract

Over the past decades, the population in Canada has become increasingly culturally diverse. Therefore, helping professionals are required to provide services that are culturally appropriate and effective. The main purpose of this research project was to understand the experiences and perceptions of practitioners in the field of social work intervening with clients from different cultural backgrounds, the challenges, barriers and facilitators they encounter, as well as their views on how services can be improved. A qualitative approach was used, where in-depth, semi-structure interviews were conducted with nine front-line psychosocial workers from a local government agency in Montreal.

Findings demonstrated how cultural and ethnic differences shape the psychosocial intervention process, as well as how participants defined cultural competence. Findings are discussed in reference to existing academic research on culturally competent practice. Participants' conceptualization of cultural competence paralleled some of the most common definitions in the literature, where awareness of one's own values and biases, as well as knowledge about the different cultures was essential. Moreover, the results showed a significant need for support and training for workers when intervening with culturally diverse clients. Implications for practice, policy and future research are presented.

Résumé

Depuis les dernières décennies, la population au Canada est devenue de plus en plus diversifiée. Les intervenants sociaux doivent offrir des services qui sont culturellement appropriés et efficaces. L'objectif principal de cette étude était d'explorer les expériences et les perspectives des intervenants dans le domaine du travail social travaillant avec des clients provenant de différentes cultures, les défis, les barrières, et les facilitateurs rencontrés, ainsi que leurs suggestions pour améliorer les services. Une approche qualitative fut utilisée, où des entrevues semi structurées ont été réalisées avec un échantillon de neuf intervenants de première ligne œuvrant dans une agence gouvernementale de Montréal.

Les résultats démontrèrent comment les différences culturelles et ethniques influencent le processus d'intervention psychosociale, ainsi que la façon dont les participants définissent la compétence culturelle. Les résultats sont examinés en lien avec la recherche académique existante sur la pratique culturellement compétente. Les définitions proposées sont semblables aux définitions présentes dans la littérature, où il est essentiel d'être conscient de ses propres valeurs et biais, ainsi que une connaissance des différentes cultures. En outre, les résultats indiquent un besoin important de soutien et de formation pour les intervenants qui travaillent avec des clients de diverses cultures. Les implications pour la pratique, les politiques et la recherche future sont présentées.

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Introduction

The purpose of this research project is to explore the impact of culture and ethnicity in psychosocial interventions when working with a culturally diverse population in the context of a Quebec government agency providing health and social services to the community. The aim of this study is to understand the experiences and perceptions of practitioners working with culturally diverse clients, the challenges, barriers and facilitators they encounter, as well as their views as to how services can be improved. Interest in this study originated from the researcher's professional work in different agencies working with culturally diverse populations. A popular theme in the discourse of service providers and scholars is the importance of cultural sensitivity and cultural competence when providing services to a multicultural population (Al-Krenawi & Graham, 2002; Betancourt, Green, Carrillo & Ananeh-Firempong, 2003; Este, 2007). However, study findings demonstrated that personal biases, stereotypes and misconceptions can, and do, influence practitioners' assessments and interventions when dealing with families from different cultural and ethnic backgrounds.

In Canada, over the past several decades, families have become increasingly ethnically and culturally diverse. The demographic makeup of Canada has been transformed as immigrants and refugees arrive from Asia, Latin America, Africa and the Middle East (Statistics Canada, 2006). Therefore, social services providers must answer a demand for services from an increasingly diverse population. Values, principles and practice standards outlined in the Canadian Association of Social Workers' Code of Ethics (2005) and the Quebec Code of Ethics of Social Workers (2003) all emphasize the need to recognize and respect the diversity among individuals in Canada and to respect the values and convictions of all clients.

During the past decades it has become more and more evident that services provided to ethnic and cultural minority groups need to consider the culture and ethnic background of clients to provide services that are appropriate and capable of answering their specific needs. This awareness was in part

prompted by the realization of the disparities in health status and quality of services received by different ethnic and cultural groups, which were a result of service inadequacies rather than differences in the level of need for services (Dunn & Dyck, 2000; Newbold & Danforth, 2003; Smedley, Smith, & Nelson, 2003; U.S. Surgeon General, 2001). In this context, cultural competence has been advocated as a possible solution to these disparities.

There are numerous definitions of cultural competence in the literature, depending on the theoretical frameworks used, but some of the most commonly used include the following elements: self-awareness, knowledge acquisition and skill development (Este, 2007; Lum, 2007; Sue & Sue, 2003). Even though cultural competence has been identified as one way to reduce disparities in health status and service delivery, it has also been criticized. Some of the critiques made include the fact that culture is viewed as static; ethnic or cultural groups are not homogeneous and viewing them as such perpetuates stereotypes and prejudices; and power differentials and history of oppressions are ignored (Carpenter-Song, Nordquest Schwallie & Longhofer, 2007; Este, 2007; Parrot, 2009).

While ethnic disparities in health and social services persist and there is a growing body of literature on cultural competence as a possible solution, remarkably little is known about how practitioners and helping professionals experience and perceive their work with clients from diverse backgrounds (Kai, Beavan, Faull, Dodson, Gill & Baighton, 2007). Considering the current awareness of the impact of culture in service delivery to a multicultural population, the goal of this research project is to explore how culture and ethnicity can shape psychosocial interventions when working with a culturally and ethnically diverse population.

A qualitative approach was chosen for this study given that its goal is to study the lived experience of social service professionals working in a multicultural setting, focusing on their perspectives and understandings. Qualitative methods focus more on the insider's perspective than the outsider's; it is person-centered, holistic and contextual, where depth is more important than

breadth (Padgett, 2008). Participants recruited are psychosocial workers practicing in a culturally diverse environment. These workers were asked to describe their experiences working with clients from different cultural and ethnic backgrounds. The research design used was a single instrumental case study. Purposive sampling was used to recruit participants and data were collected through individual in-depth interviews following a semi-structured interview guide. Interviews were then transcribed and coded, resulting in the identification and analysis of emerging themes.

The research questions addressed in this study are: How does culture and ethnicity shape psychosocial interventions? How do practitioners define cultural competence in practice? What are the challenges, barriers and facilitators encountered? What can be done to improve service delivery to a diverse population?

Chapter 1: Review of the Literature

Context and Problem Definition

The population in North America has become increasingly diverse during the past several decades. In the United States, White Americans account for 63.7% of the total population, with the Hispanic population representing 16.3%, Black or African Americans 12.6%, Asians 4.8%, American Indians and Alaska Natives 0.9% and people identified as Other Races represent 6.2% (United States Census, 2010). In Canada, the increased diversity of the population over the past decades has been due mainly to international migration. In 2006, immigration accounted for two thirds of Canadian population growth (Statistics Canada, 2008) and almost one in five (19.8%) Canadian residents was foreign-born, the highest proportion in 75 years (Statistics Canada, 2006). Prior to the 1960s, most immigrants to Canada were White Europeans, but this has since changed. Between 2001 and 2006, 58.3% of newcomers to Canada were from Asia (including the Middle East), 16.1% from Europe, 10.8% from Central and South America and the Caribbean, and 10.6% from Africa (Statistics Canada, 2006). Moreover, about one in five Canadians has a mother tongue other than English or French (Statistic Canada, 2008).

Given the recent patterns of immigration, there has been a significant increase in the visible minority population in Canada. According to the Employment Equity Act (1995), members of visible minorities are ‘persons, other than aboriginal peoples, who are non-Caucasian in race or non-white in colour” (p.2). Between 1981 and 2001, the visible minority population almost quadrupled. Between 2001 and 2006, this population increased significantly faster than the overall population of Canada, with a rate of growth of 27.2% compared to 5.4% for the population as a whole (Statistics Canada, 2008b), reaching just above 5 million individuals; they made up 16.2% of the total population of Canada. It is estimated that by 2017 approximately one Canadian in five would belong to a visible minority group (Statistics Canada, 2008). Quebec, like the rest of Canada, has become increasingly multicultural and a sizable proportion of the immigrant

population resides in Montreal. Interestingly, Quebec has been home to a great diversity of communities for many centuries, but their presence has largely been obscured by the fact that French-English relations have historically dominated the public scene (Roy & Montgomery, 2002).

In this context, it is important to examine the relationship between cultural diversity and health and social services, as well as the challenges that this situation creates to equal access to health and social services. In the United States, despite improvements in the overall health of the general population, striking disparities continue to exist in health, illness and death among African Americans, Hispanics, Native Americans, Alaska Natives, Asians, and Pacific Islanders (National Institutes of Health, 2000). As well, racial and ethnic minority groups receive a lower quality of healthcare, have less access to care, and are less likely to receive effective treatments (U.S. Surgeon General, 2001). For example, evidence has revealed that mental health services were not accessible, available or effectively delivered to ethnic minority groups, services were underutilized and treatment was terminated prematurely (Sue, 1998). In the area of psychosocial treatment, ethnic and cultural concepts may clash with conventional values inherent to traditional psychotherapies.

These health disparities have many diverse causes. Low socioeconomic status is certainly an important factor. However, there is evidence that even when minority clients are not socioeconomically disadvantaged they still have systematically different health experiences from non-minority Americans (Brach & Fraser, 2000). These disparities exist due to service inadequacies rather than possible differences in need for services or factors related to accessibility (i.e. insurance status; Smedley, Smith, & Nelson, 2003).

In Canada, inequalities between ethnic minority populations and the general population with respect to the determinants of health have also been documented (Dunn & Dyck, 2000; Newbold & Danforth, 2003). Immigrants have poorer health status and higher rates of chronic conditions, including diabetes, heart disease, and arthritis. It is noteworthy that newly arrived immigrants tend to

have better overall health than the general population (Newbold & Danforth, 2003; Vissandjee, Desmeules, Cao, Abdool & Kawanjian, 2004), probably because immigrants are screened for health problems before being admitted into the country and the fact that those who are very ill would not be able to travel. Nevertheless, this situation tends to diminish over time, even reversing the disparity (Vissandjee et al).

Recent research is highly critical of the current situation of social work practice and its endeavours to meet the different needs of the culturally diverse society (Chahal, 2004; Weaver, 2005). Minority ethnic communities continue to experience mainstream services operating upon the basis of stereotypes and erroneous assumptions. Services are seen as mono-cultural and inappropriate to meet the needs of clients in terms of language, religion and culture (Chahal). Additionally, a study of 100 cases examining clinical assessments and formulations in Montreal concluded that the impact of cultural misunderstandings was prevalent throughout in the form of incomplete assessments, incorrect diagnoses, inadequate or inappropriate treatment and failed therapeutic alliances (Kirmayer, Groleau, Guzder, Jaswant, & Jarvis, 2003).

The recognition that disparities exist in the human services sector has prompted a focus on cultural competence as a possible remedy to this problem. Because mainstream services have largely failed disadvantaged and minority populations (Oxman-Martinez & Hanley, 2005) which, as we have seen, constitute an increasingly significant proportion of the population in North America, issues of cultural differences and the impact on the service delivery have received much attention. Cultural competency is seen as a declaration that one-size-fits-all health care is not able to meet the needs of an increasingly diverse population (Brach & Fraser, 2000)

Moreover, in addition to the increased socio-demographic shifts towards a more cultural diverse population and the recognition of disparities in the utilization and quality of services for minority groups, ethical reasons have also been advanced as arguments for cultural competence. The value base of the social

work profession supports the increased emphasis on cultural competency both at the individual and organizational level. Respect and recognition for the diversity among individuals in our society and their right to their unique beliefs is clearly stated in the national code of ethics of the Canadian Association of Social Workers (2005). Social work's value base stresses that all groups, including ethnic, cultural, racial, and religious, have the right to receive competent professional services. In the United States as well, the Code of Ethics of the National Association of Social Workers (NASW) states that cultural competence with diverse populations is an ethical imperative (NASW, 1999).

Before exploring the role of culture and ethnicity in the intervention process and in the larger social services context, the terms culture, ethnicity and race need to be defined. Culture refers to the ideas, values, beliefs, knowledge and worldviews of a group of people (Weaver, 2005). It includes behavioural patterns and particular group life experiences that are passed on from generation to generation (Lum, 2007). Ethnicity refers to "clusters of people who have common culture traits that they distinguish from those of other people" (Smedley & Smedley, 2005, p.16). An ethnic group is composed of "people who share a common language, geographic locale or place of origin, religion, sense of history, traditions, values, beliefs, and food habits" (Smedley & Smedley, 2005, p.16). On the other hand, race is seen as different subdivisions of the human species associated with both physical features and behaviour (Smedley & Smedley). Racist ideology resulted in the belief that humans are hierarchically arranged into races, with characteristic morals, intelligence and cultural attributes. Most social scientists agree, however, that race is a social construct and that it has no biological basis (Christensen, 2002).

In the following sections I will explore the role of culture in providing adequate services to ethno-cultural minority groups, the definitions proposed for cultural competency, as well as challenging views to cultural competence as a solution to disparities. Below is a brief review of the history of the social work profession in relation to cultural diversity.

Social Work History and Theoretical Approaches to Multicultural Interventions

In the beginnings of the social work profession, a distinction was often made between those who deserved help and those who did not, and services were primarily targeted to those individuals identified as the worthy and deserving poor (Iglehart & Becerra, 1996). These were mostly widows, disable individuals, and those who were thought to be poor through no fault of their own. Early agencies and service providers also decided how they would serve people in need based on their race and ethnicity, establishing policies that were clearly racist. These policies failed to respond to the needs of different cultural groups (Iglehart & Becerra). This illustrates the fact that in the profession there has often been tension between the stated ideals of social workers, which condemn prejudice and discrimination, and the actual realities in practice (Weaver, 2005).

Values and standards in the helping professions come from a predominantly Euro-American perspective and as such are culture-bound and may be inappropriate when working with culturally diverse groups. These groups have seen their life experiences invalidated, their cultural values or differences defined as deviant and pathological and they have had the values of the dominant culture imposed upon them (Sue & Sue, 2003). Many standards of professional competence, which are Eurocentric, are derived mainly from the values, beliefs, cultural assumptions and traditions of the larger society; there is no wonder that services are not appropriate for members of culturally diverse groups. Social workers could be perceived as outsiders trying to impose their views and values when working with culturally different groups and many people from minority groups often viewed social workers as part of the problem rather than the solution (Iglehart & Becerra, 1996). Thus, social workers' approach to working with different ethnic groups could be viewed as coming from a paternalistic and deficit perspective (Weaver, 2005). Past and present discrimination against culturally diverse groups is a tangible cause for minority groups to distrust the majority society and may explain why White service providers may be mistrusted (Sue & Sue, 2003).

In the earlier literature of the 1950' and 1960's, there was a common theme equating minorities to pathology, where different traits, beliefs or behaviors were considered abnormal (Sue & Sue, 2003; Weaver, 2005). First, it was under a model that portrayed people of colour as genetically deficient in certain desirable attributes. For example, Whites were seen as genetically superior and Blacks were considered more aggressive. Then, there was a shift from a genetic deficit to a cultural deficit, where minorities were seen as culturally deprived (Sue & Sue). It was no longer biological attributes that caused differences, but the lifestyles and values of the different ethnic groups that caused them to be inferior (Sue & Sue). In this manner the differences in cultural values and lifestyles became equated with pathology, which perpetuated racism and social inequities. Desirable and undesirable behaviour was measured according to White, middle-class definitions. All these models assumed the inferiority of ethnic and racial minority groups.

Hence, in the early stages of the profession, when changes in the composition of the population were starting to become evident, the assimilation perspective was promoted. This perspective assumed that newly arrived immigrants would integrate into the way of life of the dominant population. People from diverse groups were expected to relinquish their ways and adopt the customs and lifestyles of their new country (Weaver, 2005). Assimilation theory viewed cultural differences as deficits that needed to be corrected. These ideas are now rejected by many researchers in favor of a culturally diverse model, where minorities should not be viewed as deficient, but rather as culturally diverse; alternative lifestyles should be recognized as legitimate and difference should be valued (Sue & Sue, 2003).

In an effort to adjust services to a diverse population, the profession of social work has gone through a number of theoretical changes. In the 1950s and 1960s, a colourblind approach was advocated to ensure equal treatment for all (Weaver, 2005). There was a move to end programs that espoused practices of segregation towards a colourblind approach, where people would be treated equally, as this was considered a fair and just approach to service delivery.

However, this ignored clients' culture entirely, which is a significant part of a person's identity, and may lead to inappropriate and ineffective services (Weaver). In the 1970s and 1980s, cultural sensitivity replaced the colour-blind approach, and it became important to recognize cultural differences as well as to develop a basic understanding of different cultural groups to provide better services. In this view, models highlighted cultural difference, multiculturalism and cultural pluralism and diversity (Al-Krenawi & Graham, 2002). Then in the 1990s, cultural competence succeeded cultural sensitivity, as it became necessary to integrate skills to sensitivity in order to lead to a more effective practice (Weaver 2005). In this view, competence goes further than sensitivity, going further than just being aware of and sympathetic to cultural issues. Competence is more skilled and knowledgeable and involves a commitment to change (Al-Krenawi & Graham, 2002).

Sociopolitical Considerations and the Impact of Culture in the Helping Relation

Social policies in Canada have shaped the experiences of ethnic minority groups, those referred to as belonging to 'other' than the two 'founding' nations, and who are categorized as 'visible minorities'. The language used is indicative of these dominant-minority relations. First, ethnic groups are identified as those people whose ancestry is other then European. However, given the definition of ethnicity previously mentioned, all individuals, including French and English, are part of an ethnic group (Christensen, 2002). Second, labeling groups of people as 'visible minorities' differentiates them from Euro-Canadians "according to the racialized feature of skin colour" (Christensen, 2002, p. 72), which can be viewed as racism. Racism exists whenever people are treated as if the socially constructed racial categories established in the 18th and 19th century truly existed. Being White becomes the default standard from where cultural and ethnic minorities are evaluated, judged and considered inferior or abnormal (Pon, 2009). Nonetheless, physical characteristics should never be included in the definition of ethnic or cultural identity, as individuals may have physical traits associated with one

geographical region, but may identify with a different culture or ethnicity as a result of immigration or intermarriage (Smedley & Smedley, 2005).

If one considers that the therapeutic context can be a reflection of the race-relations in the larger society and that the practitioner often inherits the biases of his predecessors in the field, the helping relationship between the practitioner and the culturally different client might be reflective of the dominant-minority relationship. Furthermore, clients from different cultural backgrounds may have experienced prejudice and discrimination during their life experiences and this may affect their view of the helping professional working with them (Sue & Sue, 2003). Therefore, these are important factors that need to be considered in the intervention process.

Cultural difference between social workers and their clients can have a significant impact on the helping relationship. As previously mentioned, culture shapes a person's values, beliefs and worldviews and the choices a person makes. A client's cultural background can shape the definition of the problem, how he goes about seeking help, and the interventions and solutions he sees as desirable (Weaver, 2005). Culture also shapes how symptoms are expressed and understood, as well as a person's beliefs about cause and effect. In the same manner, social workers bring their own cultural and professional backgrounds to the helping relationship, and this can influence their approach to the clients and the problem (Weaver, 2005).

When looking at different perspectives used in social work, the etic-emic perspective illustrates the gap that can exist between the worker and the client. An etic perspective is one from an outside point of view, whereas an emic perspective is one from the viewpoint of members of a particular cultural and ethnic group (Al-Krenawi & Graham, 2002). This can be particularly relevant when defining what the problem is, as the client may have a divergent definition of the problem based on their emically based culture and experience, while the worker will derive his view of the problem from his professional training and cultural assumptions.

Barriers to Practice with Culturally Diverse Populations

Barriers exist for the cultural minority populations to access and/or receive adequate services. For many Canadian immigrants, who belong to different ethnic groups, differences between their values and worldviews with those of the mainstream group, as well as with the health and social services system, can be so great that they become barriers to accessing services (Ducharme, Paquet, Vissandjee, Carpentier & Trudeau, 2007; Lai & Chau, 2007; Rifssso, 2010).

In a study done in Montreal to identify the needs of clients and professionals and barriers to service, one of the barriers identified was the lack of knowledge about available services (Ducharme et al., 2007). People are poorly informed about services, their eligibility rights and access procedures. It was also found that the possibility of being judged by other members of their community and the cultural values that prescribe family members to care for those in need might prevent people from requesting services (Ducharme et al.). Similar results were found in a study of older Chinese immigrants, where personal attitudes of clients, including feeling ashamed or uncomfortable with asking for help, were identified as barriers to access services (Lai & Chau, 2007).

Barriers identified at the organizational level include lack of diversity in the leadership and workforce of health care organizations. As a consequence, policies, procedures and delivery methods are inappropriately designed or do not adequately respond to the needs of a multicultural population (Betancourt et al., 2003). Agencies objectives may be out of sync with the real needs of clients from minority groups and the resources needed to meet their needs are not available (Graham, Bradshaw &Trew, 2010).

Language is another barrier that can have major impact in the accessibility of services. Language barriers make communication between the helping professional and client very difficult, influencing the helping relationship and the quality of services delivered. Clients are confronted with major language barriers that prevent them from accessing health promotion and prevention programs available to the general population (Bowen, 2001; Lai & Chai, 2007). Betancourt

et al. (2003) reported that lack of interpreter services and health education material that is culturally and linguistically appropriate was also considered a barrier. Moreover, language barriers might contribute to incidents where professionals inadvertently do not respect ethical principles, like confidentiality and informed consent (Bowen, 2001).

Practitioners' attitudes are another barrier impacting service delivery. When professionals fail to consider social and cultural factors in their interventions, they may inadvertently use stereotypes, which in turns affects their behaviour and their decisions (Betancourt et al., 2003). On the other hand, it becomes that more difficult for clients to mobilize themselves and look for help when they feel that the professionals offering services do not understand their culture (Lai & Chau, 2007).

Cultural Competence: Definitions and Applications

The idea that culturally competent services should be available to ethnic minority populations has been expressed for at least four decades and cultural competency is advocated and even mandated by professional organizations, government agencies and different helping professions (Sue, Zane, Nagayama Hall, & Berger, 2009). Despite this, the concept continues to be a source of controversy regarding its meaning, empirical research base and implications in practice. This section will present some of the definitions advanced for cultural competence.

There are several definitions for cultural competence put forward that have both similar and different elements. Sue and Sue (2003) state three primary goals of cultural competence: (a) a culturally competent professional is actively in the process of becoming aware of his or hers own values, biases, limitations and assumptions; (b) a culturally competent professional actively attempts to know and understand the worldview of the client; and (c) a culturally competent professional must develop and apply culturally appropriate, relevant and sensitive intervention strategies and skills. As well, cultural competence is described as a continuous process of building awareness, knowledge and skills (Sue & Sue).

For Betancourt et al. (2003), cultural competence in health care involves:

> Understanding the importance of social and cultural influences on patients' health beliefs and behaviours; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. (p. 297)

Lum (2007) states that cultural competence encompasses four areas: (a) cultural self-awareness, through an exploration of one's own ethnic identity, cultural background, and contact with people from other ethnicities; (b) knowledge acquisition of the other's culture; (c) skill development, which applies knowledge acquisition to actual practice with clients and also addresses the structure that needs to be put in place for adequate service delivery to clients; and (d) continuous inductive learning.

According to a review of the literature done by Este (2007), common themes associated with cultural competence expect that practitioners: (a) require a specific knowledge base on social diversity and oppression in relation to race, gender, ethnicity, sexual orientation, and other attributes; (b) need to be informed about different cultural and racial groups; (c) must possess empathy and communication skills to work with clients from diverse backgrounds; and (d) must have intrinsic values that truly reflect the practitioner's willingness and commitment to work in an ethical and effective manner with different client systems (p. 96).

Taking elements from several of these definitions, the National Association of Social Workers (NASW) defines cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professional to work effectively in cross-cultural situations" (NASW, 2001, p. 11).

As it can be seen, there is not one single definition for the meaning of cultural competence and most definitions consist of several components. Given that there are no clear constructs for cultural competence, it is difficult to establish practice applications based on theoretical constructs and it becomes difficult to express measurable indicators in concrete and behavioural terms (Kwong, 2009). There is a lack of clear theoretical models for multicultural counseling and insufficient empirical evidence to support the different approaches put forward. In the past few decades there have been numerous efforts to explore a variety of aspects of cultural competence, but attempts to operationalize this concept have received less effort (Kwong, 2009).

In a grounded theory study by Kwong (2009), different theoretical frameworks were advanced to achieve culturally competent practice, all positioning the practitioner as a learner rather than an expert, and emphasizing exploring and learning from the client. The focus was at the micro level, between the worker and the client, where the practitioner was encouraged to learn to integrate traditional counseling approaches with culturally competent practice. However, it has been argued that focusing on the individual practitioner is not enough and that cultural competence should be integrated throughout the different levels of practice, which include the individual, but also the organization and the larger systems (Lum, 2007). This illustrates a concern that more attention may be focused on the competence level of the practitioner than on the existing organizational barriers to effective social service provision. There will be little change if the organizations that employ the professionals who are striving to be culturally competent are monocultural and discourage these professionals from using their culturally competent knowledge and skills (Sue & Sue, 2003). The efforts and practices of service providers are often a function of the policies and guidelines of the agency where they work. In this regard, cultural competence might refer to an ongoing commitment or institutionalization of appropriate practice and policies for diverse populations (Brach & Fraser, 2000). As practitioners are frequently part of organizations or systems, they can only

become culturally competent with the support and encouragement of the health care system where they work.

Given that health professionals work in general as part of agencies or systems, cultural competence needs to be addressed by the health system if the ultimate goal is for it to become institutionalized (Brach & Fraser, 2000). Much of the literature on cultural competence discusses the importance of awareness, knowledge, skills and attitudes, but these elements focus on the helping professional as an individual and little is said about how a health system can become culturally competent. These cultural competence models fail to address institutional barriers and do not promote change in organizations (Bernard & Moriah, 2007). Responsibility for cultural competence remains with individual workers and the process of change rest with them, not the institutions.

Bernard and Moriah (2007) proposed a cultural competence model that tries to address some of the issues identified with the definitions of cultural competence, underlying that it is a journey with constant changes and adaptations. They proposed several principles that practitioners need to consider when working towards cultural competence. These are: cultural awareness, cross-cultural relations, strengths of clients, differences that exist between and within cultural groups, cultural knowledge and diversity training, adaptation of services at the organizational level, community involvement, multi-ethnic staff, assessment and evaluation of cultural competence by the agency, and empowerment and advocacy (Bernard & Moriah).

Cultural competence as seen by practitioners and community members.

Although cultural competence has been a subject of research for several decades, there is limited literature examining practitioners' or members of cultural groups' definitions of culturally appropriate services. In a study done by Rifssso (2010), leaders of different cultural communities were asked to define culturally adapted social and community services, in order for them to be considered culturally competent. They identified those services that considered the culture of

the client and that included a cultural adjustment by the service providers, including the organizations as a whole. This adaptation went from the first contact of the client with the organization to the understanding of different cultural issues by all employees. Also, included were services that respect the cultural differences of the clients, including religion, sex, social realities, traditions, and so forth. In addition, they stressed that practitioners need to know their clients' cultures in order to adapt their approaches to make clients more comfortable in the intervention. Practitioners have to recognize and accept cultural diversity as well as establish a dialogue based on respect (Rifssso, 2010).

For a group of family therapists working with Latino families, language was one of the important aspects of a successful intervention. However, being fluent in the client's language was not enough; what was important was to create a dialogical space without attaching the practitioner's own meaning to language, as an important difference exists in meaning and interpretation. In this view, cultural competence has more to do with negotiating and co-constructing meaning with clients, rather than assuming the clients' understanding (Taylor, Gambourg, Rivera & Laureano, 2006). As well, for this group of practitioners it was necessary to be aware of their own assumptions and presumptions about the clients' cultural narrative. They felt that Western, middle-class therapeutic approaches, like family systems therapy, do not address the needs of culturally diverse clients appropriately. For example, the notion of enmeshment may not be effective with the Latino families as they have a strong sense of family unity and cultural pride, and their definition of family usually extends beyond the nuclear family (Taylor et al.). It is then necessary to assess where families situate their values in the continuum between individualism and collectivism.

Outcomes of culturally adapted interventions.

Looking at the literature, there is substantial research to suggest that cultural competence should work, however, there is still little evidence about which techniques are effective and even less evidence on how to implement them properly (Brach & Fraser, 2000). Adaptations to evidence-based practices to include sociocultural elements are encouraged, given that treatment models

developed and evaluated for one population may not be equally effective with other populations (Miranda, Nakamura & Bernal, 2003). Hence, more and more research is being conducted to evaluate culturally adapted interventions and there is growing evidence that these interventions are more effective than traditional evidence-based interventions. For example, there is evidence that when culturally sensitive and relevant content was incorporated in therapy client engagement was improved, and in so doing the client/clinician relationship was also improved (Jackson-Gilfort, Liddle, Tejeda & Dakof, 2001). Furthermore, a review of the literature of Latino outcome studies revealed that the majority of studies with positive outcomes associated with measures of health, substance abuse and mental health used some culturally tailored variation of cognitive therapy in the therapeutic intervention (Jani, Ortiz, & Aranda, 2009). What remains to be explored is how culturally relevant content needs to be incorporated in the interventions in order for them to become more effective.

Another review by Jackson (2009) of the literature for culturally adapted intervention studies with ethnic minority youth revealed that only a very small number of studies in this area have been done, which illustrates the need for more research on the subject. Nevertheless, this review uncovered some progress to develop effective interventions for minority groups based on sound theoretical frameworks, as well as more rigorous design and methods to measure the interventions effectiveness (Jackson, 2009).

In general, there is evidence to show that culturally adapted interventions result in better outcomes. However, this appears to be more apparent in research with adults than on children or youths (Sue et al. 2009). As well, factors related to the practitioner, the client and the intervention might influence who will benefit from culturally adapted interventions. For example, the relevance of culturally adapted interventions will be different depending on the level of acculturation of clients from cultural minority groups; clients who have not become acculturated will probably benefit more than fully acculturated ones. As Sue et al. (2009, p. 17) stated, “individual differences as well as ethnic and cultural differences should be

considered in the nature of the intervention delivery style and content." Nevertheless, the extent to which interventions need to be culturally adapted for minority populations is still unclear and more research is needed regarding evidence-based interventions for specific populations (Miranda, Bernal, Lau, Kohn, Hwang & LaFramboise, 2005)

Training on cultural competence.

Although the idea of cultural competence has existed for several decades, there is still limited research on cultural competence training provided to professionals (Beach et al, 2005; Yamada & Brekke, 2008). In a review of 34 studies of cultural competence training in the health professions, Beach et al (2005) concluded that there is good evidence that training improves the knowledge, attitudes and skills of professionals. These are the elements that are often included in the definition of cultural competence, where the professional must possess knowledge of the other's culture, worldviews and beliefs, be aware of his or her own values and biases and how they can impact the service delivery to clients from different cultural backgrounds, and where intervention skills integrate aspects of the client's culture and worldview (Sue & Sue, 2003). They also concluded that training has an impact in patient satisfaction, but there is poor evidence that it impacts patients' adherence and no studies have evaluated patient outcomes.

Until relatively recently the subject of culture was given little attention in professional schools and training programs. This is one of the reasons there is still limited research on cultural minority groups, although some agencies have recognized this lack and are coming forward with different initiatives to address this situation (Vega, 2005). There is a perception of cultural competence as a distinct set of skills acquired, instead of being an integral, ongoing component of clinical practice. It is important to learn to incorporate clinical skills into cultural context and how to use cultural theoretical frameworks in working with multicultural clients, as well as to have practical experience with supervision and effective use of client feedback (Kwong, 2009). Cultural competency training

must be presented in the context of clinical practice and with evident and unambiguous organizational support in order to improve care. Training alone is not enough if the organizational priorities are not at the same pace or if staff lack the support of directors and clinical supervisors (Vega, 2005).

Moreover, training efforts in general have several shortcomings. Often only a narrow range of cultural issues and topics are explored. Social issues affecting cultural minority groups are usually not addressed. Typically, those looking for training are those interested in the subject, and those who would need it most are least likely to look for it. Most programs do not consider the organizational factors needed to support changes in practitioners' behaviours (Yamada & Brekke, 2008)

Challenges and Limitations of Cultural Competence

Some researchers have asked whether proponents of cultural competence are stereotyping ethnic minority clients. By emphasizing the need to understand the cultural values and worldviews of members of different cultural groups, the idea that members of these groups behave similarly is implied. This in turn can be inadvertently racist, stereotypic and prejudicial (Weinrach & Thomas, 2004). No ethnic or cultural community is homogenous in nature. For example, the Black community in Canada is comprised of individuals from many different geographical areas of the world and includes Black Canadians who are part of a long historical tradition in Canada. This cultural variation also exists within communities of origin and failure to recognize this reality can lead to stereotypes and inappropriate interventions (Carpenter-Song, Nordquest Schwallie & Longhofer, 2007; Este, 2007). There is a danger of failing to address the client's individual differences as, for example, not all members of a specific cultural group might report the same level of ethnic identity, acculturation or adherence to cultural values and worldviews. Groups do not possess a singular identity; therefore the identity and behaviour of individuals cannot be matched to an existing list of cultural traits and practices (Parrot, 2009).

At the same time, definitions of cultural competence and culture itself tend to portray culture as being fixed and static. Culture should be viewed as fluid and dynamic, subject to a series of influences and impacts (Carpenter-Song et al., 2007; Este, 2007). A postmodern view of culture implies that there is no pure, static, or monolithic culture (Pon, 2009). Therefore, it becomes extremely difficult and even useless to construct inventories and lists of different cultures and their characteristics, as they are in a process of constant adaptation. The general tendency of cultural competency approaches to focus on acquiring knowledge of specific cultural minority groups can only reinforce stereotypes.

Addressing culture as only being comprised of the general external manifestations of a homologous group ignores the issues of power differentials and places the experiences of oppression lived by minority groups only at the level of culture, minimizing the history of oppression and its structural components (Parrot, 2009). Emphasizing only cultural differences can obscure the existence of structural power imbalances (Carpenter-Song et al., 2007). At the same time, focusing only on cultural differences can induce the practitioner to blame the patient's culture for miscommunication, lack of adherence to recommendations and other challenges encountered by the practitioner (Carpenter-Song et al.).

A postmodern approach to cultural competence moves away from the idea that using specific guidelines for intervention with specific cultural groups is sufficient. When an individual presents with problems, one must take into consideration the social, cultural and political context of the situation (Taylor et al., 2006). A culturally competent therapist is one who is willing to open spaces for dialogue and to address the social roots of the problems clients bring with them. Furthermore, he or she has also engaged in self-reflecting work, as differences exist between people and not within an individual. Therefore, one needs to reflect on one's own values, behaviours and worldviews in order to be able to learn about someone else's (Weaver, 2005).

One of the greatest limitations of cultural competence literature is its "apolitical or de-political nature" (Sakamoto, 2007, p. 108). In the literature, culture is often seen as neutral, which hides the fact that the systems of oppression that motivated the rise of cultural competence still exist (Sakamoto). Practitioners are often assumed to be White and middle-class, and their diverse social locations are often ignored (Sakamoto). As noted previously, the social work profession is based on White values and Eurocentric models of practice, which automatically assume the Whiteness of the practitioner. From this perspective, non-whites are defined as the 'others', and knowledge about the cultural 'others' is created by those with the power to define meaning and perspectives, which is often done by maintaining whiteness as the default standard (Pon, 2009). Sakamoto (2007) challenges the view of the culturally different client as "other" and proposes a cultural competence model that is also framed by anti-oppressive principles, where the context of power dynamics is examined.

A cultural competence model grounded in anti-oppressive practice would challenge the assumption about the Whiteness of practitioners and the fact that the current knowledge in the field is founded on practices of exclusion (Sakamoto, 2007). Western health services are dominated by Eurocentrism, which fails to respond to the specific needs of clients from diverse cultural backgrounds and often creates barriers to service access and appropriate treatment. In order to address these issues, Williams (2003) proposed that cultural competence could be envisioned as a knowledge base that challenges and changes the systems and theories initially developed under the dominant values and knowledge and a means to respond to the needs of marginalized populations.

At the same time, in the context of anti-oppressive practice, practitioners need to account for differences within culturally diverse groups and recognize that different groupings within specific cultures can behave in a way to keep power for themselves at the expense of others within their culture (Parrot, 2009). Practitioners need to negotiate between competing claims for what constitutes appropriate behaviour within different cultures. It is necessary to show respect for

and support of cultural practices that are positive for all members, while ensuring that individuals within those cultural groups are not oppressed by those practices. As it is possible that cultural practices clash with those of the host culture, there is a need to use approaches based on cultural dialogue, where common ground can be constructed and new cultural norms can be negotiated (Parrot).

An Intercultural Approach to Practice: the Quebec Model

In Quebec, policies on immigration and integration have shaped how practitioners intervene with different immigrant communities. Before exploring this, it is important to examine the different approaches to practice in Canada and Quebec. Canadian public policies use the term 'multicultural' when describing Canada's diverse populations. Multicultural social work assumes a pluralistic context of increasing heterogeneity in ethnocultural and religious communities, characterized by different streams of new immigration (Al-Krenawi & Graham, 2002). In this model, minority communities are encouraged to develop and express the specificity of their cultures and institutions, creating a 'mosaic' of communities different from one another but sharing the same territorial space (Roy & Montgomery, 2002). In Quebec, on the other hand, an intercultural approach to practice has been favoured. The term 'intercultural' emerged in opposition to the multiculturalism of English Canada. This approach also promotes minority communities, but it sees them as being linked through a common language and shared civic values (Roy & Montgomery).

In the 1980s, the notion of culture became the dominant theme for social work practice with the culturally diverse clientele and the diverse populations living in Quebec who were designated as 'cultural communities'. According to this model, in order to adequately respond to the health and psychosocial needs of the cultural communities, practitioners had to possess a sound understanding of their clients' culture and social work practice with immigrants was designed around the idea of cultural differences (Roy & Montgomery, 2002). However, as seen in the evolution of cultural competence, this model was criticized due to its viewing culture as something static, a fixed set of values and beliefs shared by a

homogenous group. In Quebec, given the demographic changes and the resulting pressures on the health and social services system, practitioners are progressively adopting an intercultural model of practice in order to maximize the impact of their interventions with a diverse population. The development and application of an intercultural approach encourages practitioners to adopt a more open approach to service delivery (Rifssso, 2010). It emphasizes a relationship of reciprocity between the client and the practitioner, based on respect and trust (Roy & Montgomery, 2003).

For Cohen-Emerique (1993), the intercultural approach to practice is above all a helping process, based on respect for the person, his or her worldview and value system. It is an interaction between two people, each with their own identity and values. Hence, it does not focus exclusively on the 'other', the immigrant client, but recognizes the subjective nature of the practitioner. The intercultural approach is composed of three interrelated stages. First is the 'decentration' process, which allows the practitioner to better define his or her own identity. Only through a better understanding of one's own social and cultural identity is it possible to bring out the relativity of one's points of view and the danger of ignoring ethnocentrism, stereotypes and prejudices. The second stage is the penetration of the other's system of reference, which means to get to know the other's culture using an emic approach, from within the client's culture. The third stage is the process of negotiation and mediation between systems of references, which is part of the conflict resolution phase of the interventions (Cohen-Emerique, 1993). This takes us back to the concept of cultural dialogue previously mentioned in the context of anti-oppressive practices. This approach, which recognizes the reciprocity between the practitioner and client and encourages an openness that facilitates the intervention process must also deal with the challenge of finding a balance between respect for the history of the majority group and accommodation of the values and worldviews of immigrants (Roy & Montgomery, 2003). This is particularly relevant when considering the Francophone population, who play the role of the majority in Quebec, but are regarded as a minority in the rest of Canada.

Chapter 2: Research Methodology

Research Design

This research study adopted a qualitative approach to examine the experiences of front-line psychosocial professionals working with a multicultural population in a government agency. Data were obtained through in-depth individual interviews, as well as by reviewing written policies and procedures. Qualitative methods focus more on the insider's perspective that the outsider's; it is person-centered, holistic and contextual, where depth is more important than breadth (Padgett, 2008). This approach was chosen given that the goal of the study was to study the lived experience of those professionals working in a multicultural setting, focusing on their perspectives and understandings. This in turn provided knowledge and insight into service delivery and organizational policies. The goal of qualitative research "is not to reduce complexity by breaking it down into variables [as is the case for Quantitative research] but rather to increase complexity by including context" (Flick 2006, p. 98). Qualitative researchers, therefore, select individuals to participate in their study based on "their relevance to the research topic" (Flick, p. 98).

The research design used was a case study. In this approach the researcher explores a bounded system (case), or multiple bounded systems (cases; Creswell, 2007). A case study approach draws on the ability of the researcher to extract depth and meaning in context (Padgett, 2008), which appeared as the most relevant approach to employ in order to address the research questions. In this research project, a within-site study of a single case was performed and data were obtained through in-depth interviews and document review. The context studied was the diverse ethnic and cultural population receiving services from a government agency. The site for this study was a CLSC (Centre Local de Services Communautaires/Local Community Service Centre) on the island of Montreal with a significant multicultural population. In this particular area, 32% of the population is immigrant and 32.5% of the population speaks a language other than French or English at home (Statistique Canada, 2006).

The type of case study used was a single instrumental case study, where the focus of the research is a specific issue or concern (Creswell, 2007). The single case studied involved the psychosocial workers practicing in this culturally diverse setting. The purpose of this case study was to compare the multiple views and opinions of the different psychosocial workers and identify the themes that emerged from the interviews.

Recruitment and Sample

The participant population studied consisted of psychosocial workers (social workers and human relation agents, those workers who are not members of the order of social workers) working at a CLSC on the island of Montreal and providing services to the general population. For the purpose of this study, purposive sampling was used to recruit the participants. Padgett (2008) defines purposive sampling as “a deliberate process of selecting respondents based on their ability to provide the needed information” (p. 53). This sampling technique was used in order to recruit those professionals who had experience working with culturally diverse groups and who were able to represent different sectors of service provision. Recruitment was extended to all the existing programs at the CLSC providing psychosocial services.

In order to recruit participants, the researcher contacted the respective program managers in order to gain authorization to solicit their workers. Initially, the project was to be presented at the different team meetings held regularly. However, due to the unavailability of some project managers, cancellation of team meetings and time constraints, the project managers emailed a recruitment letter in English and French to their team members during the month of May 2011 (Appendix A and B). The prospective participants were requested to contact the researcher directly to schedule individual interviews. Snowball sampling was also used as a recruitment strategy, where participants were invited to inform their colleagues about the research study and if interested, they were encouraged to contact the researcher.

The inclusion criteria for this study required that prospective participants belonged to one of the five programs providing front-line services to the general population and that they had some interactions with the multicultural population in the course of their functions. Prospective participants for this study belonged to five different programs of services: Youth and Family Services, Adult Mental Health, Psychosocial Intake, DI-TED (Intellectual deficiency- Pervasive Developmental Disorder), and Homecare. The total sample for this study consisted of nine participants, who did not receive any form of compensation to participate in the study. The participants came from three of the five different programs at the CLSC (Youth and Family Services, Adult Mental Health and Psychosocial intake). The years of experience of the participants varied from 1.5 to 28 years, with a mean of 14 years. The age of participants ranged from 24 to 57 years old, with a mean of 38 years old. Of the nine participants, four identified themselves as French Canadian or Quebecois, four identified themselves as Canadian with some European background, and one participant was from a cultural minority group, which will not be divulged in order to preserve confidentiality. The education background of all participants was obtained but will not be divulged as it could also compromise the confidentiality of this study.

Data Collection

Data were collected through one-on-one in-depth interviews with nine participants. The interviews were conducted in English or French (see Appendix C and D for English and French versions of the interview schedule) according to the participant's preference. The interviews were audio-recorded and then transcribed verbatim. The interviews lasted on average one hour and they took place from May 17, 2011 to June 1, 2011. Participants were given the option of being interviewed at their work in their respective offices or available interview rooms, or any other location of their choice that would not jeopardize confidentiality. After the researcher transcribed the interviews, member checking was employed, where the participants were asked to review the transcripts and were able to make corrections or additions.

A semi-structured interview approach was used, where participants were asked open-ended questions following an interview schedule designed by the researcher. A semi-structured interview was used in order to provide consistency to the questions and at the same time allow the participants the freedom to expand on their own experiences. In order to obtain informed consent, the researcher verbally explained the research study to the participants and they were provided a written consent form in English or French (Appendix E and F), which they were required to sign.

As an additional source of data, the researcher reviewed the policies and procedures of the organization, which were available in electronic format through the agency's intranet. Over 40 documents were reviewed, in the following categories: Executive directorate, Human resources, Communication and strategic planning and informational resources, Multidisciplinary services, Nursing services, Child-family-youth and vaccination, and Finances and information systems.

Data Analysis

Data analysis in qualitative research involves preparing and organizing the data, in this case the interview transcripts, reducing data into themes by developing codes and categories, and then representing the data in figures, tables or a discussion (Creswell, 2007). Codes are "concepts or meaning units drawn from raw and partially processed data" (Padgett, 2008, p. 139) that are then grouped into categories or themes.

In this study, the transcripts were first read to identify main organizing ideas (Creswell, 2007), using the research questions as a guide but remaining open to codes emerging through the analysis. Open coding (Padgett, 2009) was used where the transcripts were reread and more specific codes and sub-codes were identified. Relevant segments in the transcripts were identified and assigned codes to them. Codes and sub-codes were grouped into categories, which were recorded in a code list (Appendix G). Once this process was finished, transcripts were reread in order that codes or categories that emerged in later transcripts could be

compared and verified with those identified earlier.

Throughout this process, NVIVO 8.0 software was used in order to facilitate the analysis of the data. The interview transcripts were imported into the NVIVO software and the transcripts were coded. The main organizing ideas identified during the first reading of the transcripts were used to create tree nodes where sub-codes could be added. At the same time, when new codes emerged from the text that did not belong to the existing tree nodes, new ones were created. In this manner, NVIVO was used in the organization of common and recurring codes across the different transcripts, which facilitated the location of important passages to be used to illustrate various themes. Codes were then analyzed and grouped into larger categories or themes.

The themes identified through the coding process were then analyzed in order to determine how they could help answer the initial research questions and how they related to the current literature. Direct quotes from the transcripts were used to illustrate these findings using the participants' own narratives. Quotes were translated to English when the interviews were done in French and the direct quotes in French are presented as footnotes. The results of this process are presented in the next chapter.

In addition to the results obtained from the interview transcripts, this researcher reviewed the available policies and procedures documents from the Agency where the participants work. This was done in order to determine the extent to which the organization considered cultural issues in its internal functioning as well as in service delivery to the community. All policies and procedures available were read to identify any information related to culture or ethnicity. The objective was to look for any reference to clients' cultural or ethnic background that could impact service delivery, including instructions on how to work with a specific population, special measures to consider or any other instance where practice was influenced by cultural differences. Moreover, internal policies related to employees were also reviewed to determine if cultural differences were considered in the internal functioning of the institution, for example, any policies regarding the recruitment of multicultural workers or

special considerations for religious practices by workers. This was done to obtain an additional source of data for the study.

Ethical Considerations

Given the fact that this study involved human subjects, ethics approval was needed from the Research Ethics Board (REB) at McGill University. The study was presented to McGill REB on April 4, 2011. The Ethics Review Administrator informed this researcher on May 4, 2011 that the study was approved pending some modifications to the consent forms. This researcher made the requested revisions to the documents and re-submitted them on May 5, 2001. On the same day, the Ethics Review Administrator informed this researcher that the study was approved and could begin.

In addition, it was necessary to obtain approval from the Health and Social Services Centre (HSSC) responsible for the CLSC where the study was to be conducted. However, there were no official forms or procedures available to request this permission. Hence, the study was presented to the consultant in charge of professional practices development, who was then able to provide verbal authorization to proceed with the research project. Moreover, the different program managers needed to authorize participant recruitment in their respective teams.

Given that this study took place at the researcher's workplace, there was a possibility that colleagues working directly with this researcher would volunteer to participate in this project. In order to avoid co-workers feeling obliged to participate, the researcher did not approach possible participants individually and the project was presented through the Program managers via emails, specifying that there was no obligation to participate and that those who would like to do so could contact the researcher afterwards. Moreover, the researcher was on a leave of absence from work during most of the research project, therefore avoiding being in daily contact with possible participants during the recruiting phase.

Confidentiality

Several measures were taken to guarantee the confidentiality of participants and their data. The audio-recorded interviews were transcribed and

identified with a number that could not be linked with participants (e.g., a random number as opposed to date of birth). All identifying information about the participants or others was removed before storage. As well, there was no nominative information collected during the interviews to protect participants' confidentiality. Whenever a person was identified as belonging to a cultural minority group during the interview, this was replaced by the terms "ethnic group" to avoid possible identification. Moreover, the name of the CLSC where the study took place is not named to protect participants' identities.

All signed consent forms as well as any additional information obtained from study participants was stored in a locked file cabinet in Dr. Ives's (thesis supervisor) office at the McGill University School of Social Work. The interview transcripts were labeled with numbers to be referred throughout the research to avoid nominative information. A master list linking case numbers and names was stored separated from all data, in a locked filing cabinet. Transcripts were stored in a password-encrypted computer and all other confidential information was kept locked in Dr. Ives' office at the McGill University School of Social Work. Only this researcher and Dr. Ives had access to the audio-recordings and transcripts files. Audio files will be kept for 6 months, and then they will be deleted. Transcripts will be kept for five years after the study is finished and then will be destroyed.

Participants were required to sign a consent form clearly explaining the research project and all necessary information to obtain informed consent (See Appendix G). Participants were able to ask additional questions regarding the research project and what was requested of them before signing the consent form. Participants were informed in the consent form that their participation was voluntary, they could withdraw from the study at any time without any consequence and any information already collected would be destroyed. All participants signed the consent form before the interviews began and all agreed to have their interviews audio-recorded.

Chapter 3: Findings

This chapter will present the major findings that emerged from the analysis of the participants' interviews. The increase in the cultural diversity of the population signifies that workers are confronted with different worldviews from their own, which can be unsettling and shape their interventions. Given that, traditionally, the social work profession is based on Eurocentric values and beliefs, clients from different cultural backgrounds may not feel services respond adequately to their needs. As seen in the review of the literature, professionals and scholars are increasingly becoming aware of these issues and strategies to remedy them have been proposed. Nevertheless, as these findings will demonstrate, workers continue to experience difficulties and challenges when working with clients with diverse cultural backgrounds.

The major themes that came to light through the data analysis process include: (a) the impact of the clients' culture on the intervention process, given that they recognized culture is part of their identity and cultural differences need to be addressed; (b) workers' conceptualizations of cultural competence, which were mainly based on the most common definitions used in the literature; (c) barriers, challenges and facilitators encountered during the intervention process, where barriers represented obstacles the participants encounter when working with this population, challenges were the situations that test their abilities as helping professionals, and facilitators represented those factors that help them in their interventions; (d) the role of training and support, to remain up to date with the current practices and theories and be able to use them in the interventions; and (e) suggestions for improvement in service delivery to a multicultural population. Quotes from the participants' interviews will be used to illustrate theses themes. All names used in this text are pseudonyms.

Impact of the Clients' Culture on the Intervention Process

Participants saw culture as part of their clients' identity and as such, it played a role in the intervention process. From their narratives, it became apparent that cultural differences need to be addressed when working with clients with

diverse cultural backgrounds. Furthermore, the professionals' perception and understanding of these differences can shape the manner in which they will intervene with their clients.

Dealing with cultural differences.

A trend in participants' narratives was the discussion of the clients' different cultures being an important, and often conflictual, element. Cultural differences between clients and social workers and how those differences shape daily life were most evident when discipline and gender roles were mentioned. As Jackie explained, "Canadians' approach to discipline is very different than a lot of other countries" where physical forms of discipline are used; therefore, the situation needs to be assessed considering the cultural context of the clients.

Dora explained that "you really see an impact [of culture] when it comes to parenting practices and hands on from small children all the way up." Parenting techniques can be very different from one culture to another and parents might have difficulties adhering to or understanding the practices in the host culture. The difficulty can be that these families are "scared of the freedom of the Quebec culture" and they have trouble dealing with this new reality.

For Susan, a school social worker, it was particularly difficult to address cultural differences when they impacted on the regular functioning of the mainstream organization. As an example, religious assertions were an issue that was difficult to manage:

> There was a big gesture of assertion from the young people who were doing their prayers at school. It was very conflictual to know how we will deal with that, because they were doing it in front of every body, they were doing it in a state of provocation.[1]

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[1] Il y a eu une grande revendication des jeunes qui faisaient leurs prières a l'école, euh, c'a été très conflictuel a savoir comment on va faire pour dealer avec ca, parce qu'ils le faisaient devant tout le monde, ils le faisaient dans une situation de provocation.

At times, professionals may have difficulties addressing what they see as the additional needs and requirements put forward by clients from different cultures. They are at a loss sometimes when faced by "girls who wear a veil and who cannot wear a bathing suit"[2] to participate in swimming activities or with "those [students] respecting Ramadan and who don't eat and then faint at school."[3]

Another instance where participants felt that culture impacted their interventions was when issues of mental health brought clients to seek help. As Sophie explained, "these are people for whom the issue of mental health is something taboo in their culture."[4] There is also the added stigma that families from different cultural backgrounds face when they reach out for help, as problems may traditionally have been resolved within the family or the community.

Accepting cultural differences is not always evident. Jackie felt that in her workplace "there's still reactions to people wearing hijabs and veils" and other cultural differences. These reactions were evident towards clients but also coworkers, as "even here there have been […] stereotypical comments made or you know, inappropriate cultural little jabs." The concern here is that "if we can't even do that [being respectful] amongst ourselves and amongst our coworkers, [how does] that translates into work with clients?"

The notion of the "other".

In the discourse of most participants, the clients from diverse cultures were often referred as the "others", who needed to adapt and integrate to the host culture. Some participants advocated for a need to be "equipped for living well in

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[2] Les filles qui sont voilées qui peuvent pas se mettre en costume de bain"
[3] Ceux qui font le ramadan pis qui mangent pas pis qui perdent connaissance a l'école.

[4] C'est des gens que l'aspect de la sante mentale c'est quelque chose de tabou dans leurs cultures.

our culture”[5] as an empowerment tool. Work with culturally different clients involved helping them understand “our culture”, which would ease their adaptation and integration. Lisa saw it as the logical step given their new reality, where the role of the helping professional was to “ bring [the client] to say listen, now you are in Canada, you are no longer in China, and it takes an adaptation to do that.”[6]

Moreover, when discussing different cultural usages or practices, participants often mentioned the fact that “it is tolerated”, that the mainstream culture is doing its part by tolerating their differences. However, Dora was able to reflect on the use of the word “tolerate” as it came to her spontaneously when talking about differences when working with diverse cultural groups:

> Like in terms of tolerating… See it’s tolerating, there’s an interesting choice of words I used, tolerate. Be open to other people’s practices and ways they do things and understanding different concepts.

Workers’ perceptions of clients with different cultural backgrounds.

Throughout the participants’ narratives, certain opinions and perceptions of clients belonging to different cultural or ethnic groups became apparent. These are relevant as they might have an influence on the intervention process. The view workers have of their clients may be shaped by their own biases and stereotypes, which are rooted in their own anxieties and fears about working with different cultures. As well, workers might have a tendency to view their clients from diverse cultural backgrounds from an ethnocentric point of view, where they see their clients’ reality from their own cultural perspective and clients’ worldviews are abnormal or inferior.

Several participants highlighted the fact that many clients belonging to diverse cultural groups are constantly struggling to attain a balance between their

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[5] Outillés pour bien vivre dans notre culture
[6] L’amener a dire écoute, la t’es au Canada, t’es plus en chine, pis ca prend une adaptation pour ca.

culture of origin and the host culture. This was especially evident when working with entire families, where intergenerational issues are amplified by the acculturation gap between parents and children. Susan, one of participants, mentioned how interesting it was to see "how they [the children] will build their identity, how they will deal with both cultures, how they will make compromises between the two, and this brings them to think about what they, what they want as values, what they don't want."[7]

When addressing intergenerational issues, the different degrees and levels of acculturation can have an impact on the issue and the intervention process. As conceptualized by Berry (2005), acculturation occurs at two levels, as it involves cultural and psychological changes to take place when two or more cultural groups come into contact. It is a process that takes time and each individual has his or her own acculturation strategies. Among family members, acculturation often proceeds at different rates and with different goals, which can cause conflict and stress. As Mary said, there can be two cultures in one family if the parents immigrated when their children were young, because the children grow up exposed to the values and traditions of the host culture and the parents struggle to maintain their culture of origin.

Susan felt that it was the children who struggled the most with trying to negotiate cultural contexts, noting "one realizes that it is the children who are now stuck between the two cultures."[8] For her, it was usually girls who had more difficulties than boys, due to their parents' traditional views about gender roles. Some cultures tend to be more restrictive and protective of girls, who may have less freedom than boys. In an example given by Jackie, conflicts arose between a daughter and her parents because to them she was becoming more like her

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[7] Comment ils vont construire leur identité, comment ils vont dealer avec les deux cultures, comment ils vont faire des compromis entre les deux, pis ca leur amène beaucoup a réfléchir sur qu'est-ce qu'ils, qu'est-ce qu'ils veulent comme valeur, qu'est-ce qu'ils veulent pas.

[8] On se rend compte que c'est les enfants qui sont maintenant pris entre les deux cultures.

Canadian peers in her manner of dressing and behaving. These "cultural clashes" had to be negotiated. Participants viewed the clients from different cultural backgrounds as being caught between two cultures and their role was that of helpers in finding an acceptable balance for all.

Several participants recognized the resilience of clients from diverse cultural groups and were impressed by their strength. Resilience refers to the capacity of the clients with diverse cultural backgrounds to cope with the stress and adversity of their situation. They acknowledged how difficult the clients' life experiences and migration paths were and admired them for their resilience. For many clients, their immigration path was not directly to Montreal and they had to live through several changes. As Carole explained, it is difficult for families to start anew, especially when they had to go through several countries and learn different languages before arriving at their final destination.

In addition to the different geographical changes these families had to go through, participants were also cognizant of the changes they faced regarding socioeconomic status. For example, as Lisa explained, some clients had established professions in their country of origin, like being doctors or engineers, but their degrees are not recognized in Canada and they found themselves "at the bottom of the ladder."

Participants were impressed by the positive attitudes demonstrated by their clients. As Jackie explained it, clients who have gone through many different changes still maintain "a positive attitude and they are so appreciative, you know, and they really don't take things for granted." Although they go through many struggles, "they managed to succeed."

Participants' Conceptualizations of Cultural Competence

Participants identified several elements as essential to the concept of cultural competence. Most of them can be traced back to some of the most common definitions used by scholars and organizations, where cultural competence involves awareness, knowledge and skills (Sue & Sue, 2003).

Being aware.

In order to be culturally competent, awareness of one's own framework of thought, biases and stereotypes is essential. For Dora this meant being aware of her view of the world, as "we look to the world through our own Eurocentric eyes, so trying to, to see things more globally as opposed to just in, in the framework that we're given." As seen in the review of the literature, the profession of social work is based on Eurocentric values and beliefs, and to become more culturally competent one needs to be aware of this reality:

> If you don't understand that your way of seeing things is only one way, not necessarily the right way, because maybe every culture is like that, but I find that our culture is very much like this is the way it's done and of course it's the right way, we have the backing of science behind us, the backing of all this knowledge and it just minimizes and, every other culture and their view points, it just says well, they're not industrialized, they don't have the type of knowledge that we do. So to be able to question that I think it's really important and that's where it starts.

Being aware also means to be conscious of one's own biases in order to avoid becoming "part of the oppression that a lot of people feel [and] experience in a day to day life, because you're again imposing your values, your beliefs, without even necessarily being aware of it." All helping professionals have different values and beliefs; the point is not to ignore them or erase them, but to be aware of them to prevent them from interfering in the work with clients. As Sophie explained, "I have personal values regarding the hijab, ok, but it will not stop me from intervening exactly in the same manner with a woman who wears one or who doesn't."[9]

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[9] J'ai des valeurs personnelles par rapport au hijab, ok, mais ca l'empêchera pas que je vais intervenir exactement de la même manière avec une femme qui en porte un ou qui en portera pas.

Knowledge about different cultures.

For all participants interviewed, knowledge of the different cultures was an essential element when striving for cultural competence. This meant that helping professionals must have a basic knowledge of the cultures with whom they work with, "to understand the culture, understand how it works, understand their rites, their ways of seeing [the world]."[10] This knowledge was necessary in order to better appreciate where the clients are coming from and their realities. This in turn is essential to "adapt [the] interventions."[11] Some participants considered this a continuous effort, as Jackie explained that she doubted that workers could "ever be fully culturally competent, because […] there are so many different cultures to learn and to know. I don't know if we can ever really master all of them." Knowledge of the culture also includes all the daily customs and protocols, for example "in some cultures, religions, a woman can't shake a man's hand, or you don't look at them directly in the eyes."

This view of gaining knowledge about their clients' culture brings back the idea of culture as static, which was highlighted in the review of the literature. However, some participants appeared to recognize somewhat the limitation of viewing culture in this manner. Jackie explained "each person, just like us, takes some parts of their culture and not others, so each one exercises it differently." In this manner culture might be static but each person belonging to a cultural group can take ownership of their culture and integrate the elements that are important to them depending on their situation.

Clients as experts.

Although all participants agreed that they needed to possess a knowledge base about the different cultures with whom they work in order to provide culturally competent services, most also agreed that the clients are the experts in regards to their own culture and they are a valuable source of knowledge. Clients

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[10] Comprendre la culture, de comprendre comment ca fonctionne, de comprendre leurs, leurs rites, leurs façons de voir [le monde].
[11] Adapter mes interventions

can teach workers about their own culture and how it impacts their lives; and this could be more appropriate and relevant to include in the intervention. In this manner the intervention will be based on those cultural factors that are important for the family and not some general or stereotypical idea of what their culture is.

Dora shared some of her concerns in regards to asking the clients about their culture, because they might see her in a more unfavourable light due to her lack of knowledge:

> In terms of my learning I've always learned through the client… it's awkward because I will ask questions to try and understand, but at the same time you don't want to. It's always a fine line in how you do that, because you don't want to come across as…because some of these questions for them, the answers are so evident.

Asking the clients about their culture can also show that the helping professional respects them and values their opinion, which in turns helps facilitate the therapeutic relationship. Jackie felt that clients appreciate when workers show interest in their culture and demonstrate an effort to understand their worldviews.

Workers' approach.

In order to be culturally competent, participants stressed the importance of the approach or attitude taken by professionals when working with clients with diverse cultural backgrounds. First, helping professionals need to be open-minded and willing to accept different ways of seeing the world. Carole stressed the importance of being "open-minded also, to be non-judgmental, which also applies to any type of intervention." This means accepting other ways of doing things beside what we know and are comfortable with. In order to do this a certain attitude is required, which some participants feared was not possessed by all helping professionals: "Not that I want to be negative, but some people will, will remain, will keep their own opinions … some people won't change their views on different cultures."

Second, helping professionals need to be respectful of their clients and their traditions. They need to show the clients that they respect them as individuals and that their opinions are valued, which is something that "applies to just social work nature." This is clearly stated in the CASW Code of Ethics (2005), where the first value is the "respect for the inherent dignity and worth of all persons" (p. 4). In that sense, respect is due to all those seeking services, independent of their culture.

Moreover, with regards to clients from different cultural groups, professionals need to show respect for their traditions, their values, their way of life. This involves "respecting values and […] rituals that are practiced." Interventions need to be designed in such a way that they will be acceptable and appropriate to the clients. As Mary said, professionals must "create an intervention that's going to still respect their traditions and the way that they want to continue to live." For example, Lisa made an effort to be aware of different cultural holidays, as this could have an impact in the manner her interventions could proceed.

Finally, helping professionals must adapt to the clients in order to be culturally competent. They need to understand that clients from different cultural backgrounds might not have the same understanding of the problem issue as they do. In order for their intervention to work, they have to start where the client is. As Sophie explained, "it is accepting that sometimes we don't push things in the same direction that I would like according to my own culture."[12] Sometimes participants feel that they are working harder than their clients, but it is essential to realize that it is not that they are working harder, but that they "are not working in the same direction." Adapting to the clients also means analyzing how the current processes and procedures can be modified to better serve the clients with

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[12] C'est d'accepter que des fois on pousse pas les choses dans le même sens que je le voudrais en lien avec ma culture

diverse cultural backgrounds, "as opposed to just imposing […] the rules on, without questioning what those rules really mean."

Role of the organization in promoting culturally appropriate services.

Most participants viewed the organization where they work as having an important role in providing culturally competent services to clients with diverse cultural backgrounds. This parallels what other researchers (Brach & Fraser, 2000; Lum, 2007) have argued, as individuals work within organizations and these must support their efforts and commit to appropriate practices and policies for culturally diverse populations. For Jackie it was absolutely necessary that the organization took an active role in its workers' efforts to be more culturally competent, because "if that's not even sort of a policy that is coming down as an organization, then how are we supposed to translate that to our clients?" Another manner in which the organization can support professionals was "having the resources available for [its] workers to be able to be culturally competent." At the present time, most participants felt that becoming culturally competent is a "very individual" process, where each professional works towards improvement on an individual basis. The danger in this kind of system is that some workers may not have the inclination or the interest to do so, or may not be even aware of their shortcomings, as there are no well-defined standards of practice.

Jackie also lamented the lack of a clear policy regarding issues of cultural differences, as there had already been some incidents of inappropriate behaviour by some workers as a result of cultural differences and no disciplinary steps had been taken. These types of incidents have been tolerated and it is in those situations that "the higher-ups" need to step in with a clear message that service provision must be culturally appropriate and universally applied.

Barriers

Throughout the service delivery process, participants identified several barriers encountered when working with clients from different cultural or ethnic groups. These included cultural accessibility of services, the clients' perception of the helping professional, lack of information and resources, and language.

Culturally accessible services.

When discussing service provision to clients with diverse cultural backgrounds , the first thing that one must consider is whether or not the clients can actually access those services. It would be of no great consequence if the existing services were culturally appropriate if they are not culturally accessible to clients in the first place. For several participants this issue of accessibility was one of the main barriers to serving the multicultural population.

There were several aspects about cultural accessibility that were brought up through the participants' narratives. For Dora the issue involved the procedures put in place by the organization for clients to request services. For example, the intake procedures are not such that they facilitate the process for clients making the decision to seek help, as intakes in the Mental Health program are done over the phone. This is because referrals are received from different sources (doctors, hospitals, other programs) and before they can make a decision to accept the client, they need to assess his or her current situation. Given the great demand for services, this process needs to be fast and efficient, and is now done over the telephone. For many clients belonging to different cultural groups, the first step, which is making the decision to reach out to the organization, is quite difficult to do, and having an intake process over the phone can be quite disheartening. Moreover, it is difficult for the workers to capture cultural nuances over the phone.

Other participants highlighted the lack of adaptability of services to the clients' cultural reality as being an access barrier for many. Clients have to come looking for services at a "big box" of an organization, where services are somewhat standardized for everyone and it is up to the client to adapt to them and not the other way around. Some services can be described almost as belonging to the one-size-fits-all model and do not consider the different clients' realities. To illustrate this, Carole gave the example of an immigrant mother who would like to learn French. However, courses are only offered full time, therefore, she cannot take advantage of this service because her values dictate that she needs to be

home when her children arrive from school and have supper ready for her family. That's her reality.

In order for services to be accessible, they need to be welcoming of all clients, whatever their cultural background. If clients could identify themselves in the organization and the services offered, it would greatly facilitate accessibility. For example, at present all information and pamphlets are provided in English and French, but if clients could see that it was also available in their languages "it would really be welcoming to other cultures."

Clients' perceptions of the helping professional.

For several participants, the clients' view of them, their role and their mandate was often felt as a barrier to providing adequate services. One of the main issues was how clients perceive the profession of social work. Many clients will immediately associate the term 'social worker' with Youth Protection and would be hesitant, if not fearful, to receive services from such a professional. This was particularly relevant for participants working with schools and families. In the school settings, Jane felt that social workers are "used as a boogieman, it's a real barrier." In order for parents to follow the recommendations made by the school professionals, the school staff would sometimes present the services of the social worker as the last alternative before making a report to the Youth Protection Department.

Immigrant families associate social workers with the idea that their children could be taken away from them. Susan explained that parents are "scared of someone taking away their children, it is really the social worker who takes away children."[13] For her, much of her work involves educating the clients as to what the role of the social worker really is and understanding the mandate given by the organization. Participants also felt that being from a different culture than their clients, specifically being White, was perceived as a barrier. Carole felt that

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[13] Une peur qui leur arrive qu'on leur enlève les enfants, c'est vraiment la travailleuse sociale qui enlève les enfants.

clients would not trust her expertise because she was not from the same culture. Moreover, depending on the life experience of diverse clients, there may be a lack of trust with the helping professional. Minority community groups have a history of being poorly served by the social work profession and this continues to linger and be a factor in the current dynamics of service delivery.

Lack of information and resources.

Having the relevant information about the services available and the rights to those services is also an essential element when discussing adequate service delivery. Some participants felt that there is a clear barrier when clients are not aware of what services exist which could be of use to them and that they have equal rights to request those services. Lack of information can also be from the perspective of the helping professional. Mary, one of the newer participants in the CLSC, commented that not knowing about her clients' culture when trying to work with them is a great barrier. As well, she felt that it was hard to get to know what resources were available in the community when one starts as a new worker.

Furthermore, lack of adequate external resources was also a barrier for some participants working in the Intake or Youth and Family programs, as part of their mandate is to refer clients to external services. Resources that adequately meet the needs of clients from cultural minority groups need to take into account the specific needs of these clients, which is not always the case. Sophie gave the example of Muslim women, many of whom "cannot go to a place where there's going to be men, so they need something that's specific to their needs."

Nathalie felt frustrated as a professional because she found herself in a position where she understood the clients' needs and what was required to meet them, but could not provide the necessary resources. For example, referring to a case with South Asian clients, she said:

> [T]hey come in and they're low-income family and they need help with food. As you know Indians eat different food, you know. They need their rice; they need their dhal, lentils and such things. So referring them to

> Fond de Depannage doesn't really help because it's not part of their diet. So then what? How are we supposed to help this low-income family? Sorry we can't help you. The best we can do is the Fond de Depannage. Eat spaghetti.

Although some participants expressed that culturally appropriate resources were generally lacking, the ones that actually exist were considered to be facilitators in the intervention process. For example, Jackie greatly appreciated having access to a resource in Montreal who deals primarily with refugees and asylum seekers, as they could provide support navigating the immigration system.

Lack of resources within the organization was also highlighted. Due to budget cuts and restrictions, participants deplored the lack of specialized educators and other professionals who could complement their work with clients with diverse cultural backgrounds. Furthermore, time was also identified as being an issue. Susan commented on the fact that usually it takes more time to work with families with diverse cultural backgrounds. Building a rapport and a relationship of trust are essential in order for the intervention to be effective. However, in an environment where resources are limited and workers are expected to provide services to increasing numbers of clients, time is a luxury not always available, and therefore the quality of service is compromised.

Language.

Language was an issue for most participants, as it directly impacted their work with clients from different cultural groups. Two aspects of this issue emerged. First, how language differences made the intervention process that much more difficult, and second, how the use of translators impactd the delivery of services.

The main problem identified by participants was the difficulty to "convey their message."[14] Sometimes it is difficult for some professionals to understand

[14] Transmettre le message.

what their clients are trying to express, which in turns affects their understanding of the situation and consequently, their interventions. Dora felt this had an important impact in her interventions:

> [T]here's time that she doesn't always understand what I'm saying to her or she's not always able to express fully what she wants to say to me. So I keep, I work a little bit differently with her than I maybe would with other clients, because I recognize that that's a factor.

When helping professionals cannot speak the same language as their clients, the entire intervention process becomes more complex. For Nathalie the most difficult part was that, because of the language barrier, she could not "connect with them." Jackie expressed her frustration sometimes, when the language difference made her job that much harder: "I had that lady who only spoke Punjabi, I couldn't even make a phone call to set an appointment with her on my own."

Language was also an issue when dealing with exterior resources. Helping professionals who work at the CLSC often have to refer their clients to outside resources for specific services. The problems arise when they know what services are needed but they are not provided in the language of the client, so the referral is not made. Using a translator to address the language barrier could become an issue in itself. There are inherent complexities when using a translator during the intervention process. For many participants, it was much harder to build a trusting relationship with their clients when using a translator, as "you're not always sure that you're getting all the nuances in how they're responding." Given the nature of the work, using a third person to do counseling can be extremely challenging, especially if the worker feels the "interpreter sort of put her own spin on things."

Some of the techniques used by different helping professionals do not adapt well to the use of translators. For example, Dora expressed her concern

using a translator to do cognitive behavioural therapy, as part of her intervention has to do with the clients writing things down. For her, using a translator in this situation can be extremely difficult, because verbal and written messages would have to be translated. Working with a translator means trusting that a third person will transmit the message from the client to the worker, and vice versa, in a faithful manner. However, participants felt that this was not always the case. Moreover, sometimes the translators' bank is quite restricted and different professionals end up using the same translators for diverse situations. Jackie provided the following example:

> I think in that situation there was a bit of sort of an alliance between the interpreter and the client. And apparently they had met in another context, because there is not a huge bank of, this was Urdu I believe, so there is not a huge bank of Urdu interpreters, so sometimes they fall on the same interpreter and they get to know each other and the mother had known this interpreter from another context, so the interpreter was like 'she is a nice lady'.

Moreover, participants had experienced situations where the translator appeared to be doing more than just translating the actual words of the clients, which could in fact completely change the understanding of the presenting problem and, consequently, the intervention. On the other hand, Mary appreciated the fact that the translator was able to provide her with "cultural information about why maybe, where maybe certain things are coming from." Because often translators are members of the clients' culture, they are able to provide workers with some background information about the clients' culture and traditions. Nevertheless, caution needs to be applied in these situations, as they could come from the same culture but from a different group within that culture.

In terms of accessing translators through a government agency, participants provided mixed responses. Some participants accessed that resource often when they felt their clients would benefit from having a translator. They found the process "fairly easy to do through the Agence, you just have to call and

they send people in." Others admitted never using translators. One participant was not even aware that this was an available resource.

At times, some participants indicated that they used colleagues who speak the clients' language, or even clients' family members who speak English or French, as translators. They use this strategy to accommodate clients and make the process smoother. However, this brings about other concerns, as there might be "conflict of interest" and confidentiality issues involved. For example, when children are used as translators, a power imbalance could be created, in addition to exposing children to information that is not appropriate for them. Or when conjugal violence is an issue, having a husband or a family member translate for the victim is a clear conflict of interest.

The only participant from a cultural minority group admitted having been asked to act as a translator by her colleagues on several occasions. This proved to be complicated, as it was difficult for her to separate her role as a translator from her natural role as a helping professional. On one hand she had to transmit the exact words of the worker and client, but on the other hand she would instinctively use her clinical skills to communicate with the client, regardless of the words used by her colleague.

Challenges Working With a Multicultural Population

Working with clients from different cultural backgrounds can become challenging for some helping professionals. Whereas barriers represented obstacles the participants encounter when working with this population, which make their work that much harder, challenges are the situations that test their abilities as helping professionals. In this regard, analysis of their narratives revealed four such challenges: adapting to the client, clients' expectations, their role as resource workers, and dealing with stereotypes and misconceptions.

Adapting to clients' reality.

Most participants identified the need to adapt to where the client is in term of their cultural context as challenging. This involved their understanding of the

presenting problem, as well as the possible solutions or strategies put forward in the intervention process. An area where this was particularly difficult is mental health. Dora believed that people's definition and understanding of mental health issues and the methods of treatment are very much shaped by their beliefs and traditions: "it's sometimes difficult because every culture has their own take on mental health. Some cultures don't even prescribe to the idea that, of certain things such as depression." Hence, the work of the helping professional involves understanding what the client's beliefs are and adapting the intervention in such a manner as to make it acceptable for the client. At the same time, helping professionals have a responsibility to provide certain treatments that are prescribed; therefore, they need to find a common ground for both parties to arrive to an acceptable solution.

Nathalie commented on her own frustration when she could not bring the clients to understand and accept her explanations of the problem. This was particularly true when addressing mental health issues, as some clients with diverse cultural backgrounds prefer to consider "mystical and spiritual" elements instead of accepting medical diagnoses, like depression or schizophrenia. The challenge then becomes naming and normalizing the issue and helping the clients accept at least in part the help provided, which can be frustrating when confronted with clients' firm views of the problem.

When working with clients with diverse cultural backgrounds, professionals are often confronted with unknown traditions and expectations. Furthermore, they need to accept them as being an integral part of their clients in order to be able to build a therapeutic relationship. For example, in some cultures hospitality is an essential element of their life and workers are often faced with some sign of hospitality from their clients. But for workers who are not used to this, it can be quite unsettling. Carole felt that it was extremely difficult for her to say no to the family offering her food, but at the same time she felt uncomfortable accepting it. She believed "that's the biggest challenge because you need to respect their culture and you're also trying to build a relationship with them."

Helping professionals are trained according to specific methods and approaches and sometimes clients from different cultures do not fit into these models of intervention. Often one can hear professionals explaining the failure of an intervention by the fact that the client was resistant or was not ready to work on the issues. However, as Dora stated, it is important to verify the part that culture has in the situation:

> [T]he challenge I guess for myself you're trained to work in a certain way. So when you're working with clients you're always struggling when clients don't fit into that mold, so you have to adapt and you have to, because it's easy to say oh the person is not ready or they're resistant, but you have to be able to be, have enough insight to say how much of it is resistance, how much of it is cultural aspects, and that's always difficult, you know, that's a, that's a challenge.

Clients' expectations.

Helping professionals in general try to do their best to help the clients who come in for help and services; that is one of the main values of the profession. However, at times, clients' expectations regarding services can be more than what workers are able to provide and this can cause tension and frustrations. Nathalie provided the following example:

> An incident that we had, this was actually with a Muslim, Pakistani Muslim I think, and he needed help with dental work and we told him, we gave him resources […] And we gave him resources but we said it was at a low cost, you know, because he was a low income, that it was a low cost resource and everything, and he was really upset and he started getting upset at the worker saying that 'no I've worked in this country for thirty some years, I deserve to get this service for free'.

Sophie felt that some clients from different cultural groups have a sense of entitlement; they are due the services and resources they are requesting. They are not satisfied with what can be offered to them and they show their dissatisfaction to their workers, who then feel frustrated and unappreciated because they "can't

do more." The challenge is then not to transfer this frustration to the clients and remain professional.

Being a resource worker.

Part of the role of the psychosocial workers practicing in a context of front line work in the CLSC is to be a resource for clients. This means that clients can be guided through specific procedures or referred to appropriate outside services. For some participants this can become a challenge when the clients come from different cultural backgrounds, especially when inquiries concern those areas involving immigration issues. Jackie found the immigration system especially complex and often struggled to help her clients through it. This causes stress for workers, as it is their mandate to provide the requested guidance to the clients. Lack of knowledge and understanding of the system and limited access to the necessary information prevents them from fully realizing their duties.

This role of resource person can also translate into being a source of information for coworkers when the professional belongs to a specific cultural group. This situation can also become challenging. Although this was only voiced by Nathalie, the researcher felt it was important to include her experiences in the results. She stated: "the fact that I'm the only [ethnic group] worker there, it becomes very difficult, because I think a lot of people come gravitate towards me for education." Although she was more than happy to provide information to her colleagues, it becomes and added responsibility. In the current context of budget restrictions and increasing demands to front line workers, this added responsibility can become a challenge to manage.

Stereotypes and misconceptions.

Although being culturally competent often involves being aware of one's own biases and stereotypes, as well as an attitude of openness to the client, some participants felt that there are still instances where personal biases are hard to manage or be put aside when working with clients with diverse cultural backgrounds. Jackie believed that there are still a great number of stereotypes and misunderstandings "about a lot of cultural norms and traditions and rituals, even

among professionals." Nathalie explained that it was difficult for workers to avoid making assumptions and having prejudices, as they are human; the challenge is acknowledging how those assumptions might shape one's practice, and then trying not to judge or be biased. In addition, Dora believed that within colleagues and collaborators the issue of racism was still very much present:

> I think that at a level, no matter what people want to say, there is racism in Canada, it's more subtle I think than in other places. I think that sometimes there's issues that people aren't, the same sort of efforts aren't put into somebody who may be has a mental health issue and comes from another country. There's not sort of the same perseverance, it's a concrete example, for me I just found I was kind of shock when an individual who had, who was going to lose her house because of mental health issues and there was a public curator supposed to come in and the comment I had from another staff was 'just well let it happen, let it go through', and I found that hard to believe that if this individual had maybe been say for example French Canadian if the same attitude would have been taken.

Facilitators in the Intervention Process

Although participants identified several barriers and challenges that they have to address when working with clients with diverse cultural backgrounds, there were some factors that emerged in their discourse which facilitate their practice with this population. These include the attitudes adopted with clients and the presence of culturally diverse workers.

Attitudes.

In order to build a therapeutic relationship, the helping professional must possess some qualities and be able to show empathy and understanding of others. For some participants their attitudes towards their clients acted as facilitators in the intervention process and services delivery in general. Participants expressed that having an attitude of "respect for others" and being available and welcoming to help clients helped facilitate their work. For her part, Mary believed that

showing interest in the clients, their culture and their beliefs would help build a rapport with them and facilitate the intervention process:

> I find that when you're open and you ask questions and you show the client that you want to learn about their culture and you want to see how it plays out in their daily lives, and that kind of helps build a good rapport and helps the process.

Attitudes towards clients with diverse cultural backgrounds also can include being willing to go into their environment, where they feel more secure and safe. For Susan this was done through home visits, as this makes the intervention process easier for families and it is "less threatening." In this context, workers willing to do home visits are showing the clients that they want to know their milieu, they want to understand their customs and beliefs and they are cognizant of their fears and concerns accessing services directly at the CLSC.

Culturally diverse workers.

Most participants were in agreement regarding the importance of having workers from diverse cultural backgrounds in the organizations. Although it was not possible to determine the exact number, participants felt that the vast majority of the organization's workforce was White. The benefits of having a culturally diverse workforce are twofold. On one hand, having workers from different cultural backgrounds in the organization provides a pool of knowledgeable resources about different cultures. For participants, using the knowledge of workers from other cultures can prove extremely valuable when working with clients from different cultural backgrounds. Jackie stated that workers from different cultures "understand, have a bit more of a background on what are some of the norms and values of that culture, so they can teach" the mainstream workers. Furthermore, "sometimes a client is less trusting of working with someone from a different culture." Therefore, if there is a possibility of providing services through someone of the same cultural background, this could facilitate the process.

On the other hand, working closely with professionals from different cultural backgrounds also encourages mainstream workers to become more knowledgeable and accepting of other cultures. For Jackie, getting to know someone from a different cultural background and learning to appreciate that person on a personal and professional level was more powerful than just being told about different cultures. Similarly, accessing culturally diverse community organizations was also considered by participants to facilitate service provision. Having contacts within the different cultural communities and accessing their resources can be pertinent for the intervention as well as beneficial for the clients. By connecting with the different communities "you find out different ways of doing things, different ways of thinking."

However, there is a danger that colleagues from different cultural backgrounds feel like "the token Indian, or the token Arabic person." Having a greater number of professionals from different cultural backgrounds would help address this issue. Being the only worker at an agency belonging to a particular cultural background might feel to some as an empty gesture by the agency to deflect criticism. Although one cannot assume that an additional person from a specific cultural background would automatically become a resource worker or an automatic ally, this could improve the situation for workers from different cultural backgrounds.

Training and Support for Professionals

One element that came out in all the participants' interviews was the issue of training and support. All of the participants highlighted the great importance of training in order to remain up to date with the current practices and theories and be able to use them in their interventions with their clients. This was particularly obvious when dealing with culturally diverse populations. Helping professionals need to be knowledgeable about what types of intervention are more appropriate with different cultural groups in order to provide better services. What emerged from the participants' narratives was a sense of frustration at the lack of training available to them to improve their skills and the little support they received while

doing their work.

Availability and need for training.

Training on cultural issues related to psychosocial interventions was flagrantly lacking according to all participants. Several participants stated never having had any training specifically on cultural issues and the others who did receive some training stated that it was many years ago. Two participants mentioned having received some training related to different cultures during their studies, but they found them very vague and general, and they did not feel it left a lasting impact in their way of practicing. Others received some form of training several years ago through external organizations, but most participants expressed a feeling of frustration and blamed their current employer for not making it a priority. For Mary, training was especially relevant in her situation as a new worker, because she was not only trying to learn to do her work properly, which was already demanding, but there was the added element involving cultural issues to consider.

Throughout the discourse of all participants the need for adequate cultural training was evident. As Nathalie explained: “workers are bombarded with these South Asian families and they don’t know what to do with them.” Jackie felt training on different cultural issues was extremely important, given that the workforce was mostly, as she described, “Caucasian” and does not have the knowledge or background needed to understand the needs of culturally diverse clients.

Training on different cultures that are currently misunderstood would facilitate the intervention process, as workers would be more sensitive and less afraid of different cultural groups. Sophie felt that training should be focused on the specific populations belonging to the CLSC’s territory. In this manner, workers would be able to incorporate the relevant cultural issues into their interventions. In order to do so, the community organizations from different cultural groups in the area could be solicited to provide professionals at the CLSC with information about their respective community groups. At the same time, this

would help build links with the different organizations.

Being self-taught.

Most participants understood the importance of having knowledge and training about different cultures and learning how to intervene with a multicultural population. Given the lack of resources for training provided by their employer, they managed to educate themselves on the subject. Participants looked to expand their knowledge of different cultures by reading, looking up information in the Internet and consulting other organizations providing services to clients from different cultures.

Mary lamented that professionals who want to be better prepared to provide services to a multicultural population will have to do it on their own. However, as seen in the review of the literature, the danger of not having a structured approach to training employees resides in the fact that not all professionals will make the same efforts or will have the same interests in doing the research and educating themselves. This in turn can result in services not being of similar quality and appropriateness.

Absence of support and structure.

As it was the case with training, many participants expressed their concern regarding the lack of support or supervision in their work environment. This was a general issue, but it was particularly felt in regards to work with clients from different cultural backgrounds, because this population was becoming increasingly present in the territory of the CLSC. Most participants lamented not having regular supervisions, and some had not had any supervision in quite a long time. Some professionals found creative ways of meeting this need by discussing with colleagues and giving each other the much needed support.

Nathalie explained that the work environment was not favourable for supervision and workers have to manage on their own. Hence, they have to be creative in order to find the answers they need by looking for support from colleagues and other external resources. Dora explained that the support received

when dealing with cultural issues depended on who the manager was and what type of professional background he or she has. If managers come from a social work background, they may be more understanding of cultural issues and would reinforce the importance of providing culturally appropriate services. She felt that other professions might not have this understanding.

To complement the findings obtained through in-depth interviews, the researcher reviewed the electronically available policies and procedures of the organization employing the participants in this study. There was no specific policy or procedure that would provide guidance when intervening with a multicultural population. In addition, all other available policies and procedures were reviewed in order to determine if they included some elements regarding culture or cultural competence. However, based on the reviews, none of the policies or procedures addressed culture in any manner. This demonstrates that the issues regarding culture and cultural differences have not yet been formalized within the organization and that more work remains to be done in this respect.

Suggestions for Improvement

Most participants had suggestions for improving services to the diverse population they serve. They ranged from adopting specific attitudes, like openness and adaptability to clients' needs, to having more specialized resources. Some of the suggestions made had to do with being flexible and able to adapt the method of providing services. Susan felt that established intervention practices need to be flexible to make the services more relevant and accessible for the clients. For example, when clients feel the need to bring their extended family or any other person from their community into the intervention process, they should be accommodated. For Lisa, it was important to be able to adapt to the client and be flexible regarding case assignments. Presently, there appeared to be some rigidity in the manner cases are assigned. Therefore it was suggested that the needs of the clients be considered as the priority when assigning cases and not whose turn it is to receive a case.

Other suggestions involved having more documentation and services available in the clients' language. This would facilitate the process for the clients and would make them feel that they have a place in the organization, that they belong there too. They would be able to identify themselves somewhat in what services are offered and the organization would appear more "welcoming" to them. Lisa suggested that information and posted signs should be trilingual, after seeing something similar when she was in the United-States, where signs were also in Spanish.

Some participants suggested training as a way to improve services, as well as a strategy for workers to be more culturally competent:

> [T]o add more conferences and have more discussions for professionals to educate, you know, or to have someone organize them, our chefs de programmes [program managers] to organize them and talk about such sensitive topics for different cultures, so definitely we need more talks to be organized and educative for our workers.

Mary stressed the importance of training for newer workers, but also for those who have been around for some time. Newer workers had the opportunity to learn about the idea of culturally appropriate services in their school training, as this is a more recent focus. However, more senior workers might not have had that opportunity and training would expose them to newer ideas.

Two participants suggested having a resource worker available who would have extensive knowledge on the subject of culturally diverse cultures and appropriate interventions. In this manner, support would be readily available for them when needed, as they could have clinical consultations when they needed it. Other participants suggested having more professionals from different cultural groups working in the organization. As one participant explained, "there needs to be more diversity within the CLSC." For these participants, having a more multicultural staff would help sensitize other workers to different cultures and be more attuned to their needs. For Dora, to have the opportunity of working in the

context of a "multiethnic team" meant that workers were more sensitive to issues of cultural diversity. Moreover, an increase in staff cultural and ethnic diversity would reduce the pressure that workers from different cultural backgrounds already working in the organization appear to be experiencing, as voiced previously by Nathalie.

Several workers suggested that a central step in improving services was to reach out to clients from different cultural groups. This could be done by "going to different communities, whether the temples or the actual community centers, and kind of educate the population about the services at the CLSC and that there is help available." Another way to reach out to clients from diverse cultural backgrounds would be to make "links in the community, the different organizations" where people from different cultural groups associate and be more present and visible. Dora recognized the limited mandate of the CLSC in terms of reaching out to clients, where the established procedures is for clients to come looking for services. Nevertheless, she still believed that reaching out remained imperative. Nonetheless, not all participants were of the opinion that their role involved reaching out to clients. For Lisa, it was the choice and responsibility of the clients to look for services:

> These people do not isolate themselves. If people believe they isolate themselves, I don't believe it. They are not isolated; they are capable of looking for help. Services are there, nobody is going to go get you by the hand to give you services. If people want to stay isolated, it is their right.[15]

This chapter described the findings from the analysis of the participants' interviews. They showed how the clients' different cultural backgrounds could have an impact in the intervention process, where workers must address cultural

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[15] Ces gens-la ne s'isolent pas. Si des gens croient qu'ils s'isolent, j'y crois pas, ils sont pas isoles, ils sont capables d'aller chercher de l'aide. Les services sont la, personne va aller te chercher pas la main pour te donner des services. Si les gens veulent rester isoles c'est leur droit.

differences and their own biases and prejudices. Participants provided their own conceptualizations of cultural competence, which are similar to common definitions in the literature, but omitted considerations of culture as fluid and of the history of oppression and power imbalances. Several barriers, challenges and facilitators were identified, as well as suggestions for improvement of culturally appropriate services. These elements will be further discussed in the next chapter.

Chapter 4: Discussion and Implications for Policy and Practice

In this chapter the key findings of the study will be presented and the relevant connections to the current literature on the subject will be highlighted. As well, the limitations of the study will be explored. In addition, implications for policy, practice and future research will be discussed. The findings from the analysis of the participants' interviews provide interesting insights into the current role of culture in psychosocial interventions. Although, the concept of cultural competence has been discussed in the literature for several decades, the findings indicate that, at least in the context of this study, there is still a need to transfer academic knowledge to the actual practice environment.

Discussion of Significant Findings

Culture and the intervention process.

One of the goals of the study was to explore the role of culture in the intervention process within the context of front-line psychosocial professionals in a local government agency. The findings from the interviews with front-line psychosocial workers demonstrate that one needs to consider the impact of clients' and the workers' cultural background in the intervention process.

While working with a multicultural population, workers' own biases can shape their perception of the client and in turn the intervention process. In this study, participants identified the need to be aware of their own biases as one element in becoming a culturally competent professional. This was so because they acknowledged the fact that biases and stereotypes are present and can impact how they see their clients. Self-reflection is an important value in social work practice (Weaver, 2005) and social workers must examine their own anxieties and fears when confronted with different cultures, as these may be the roots of stereotypes and prejudices.

Ethnocentrism is the natural tendency of people to view reality from their own cultural perspective and the belief that the way they see the world is the correct or normal one, and others are abnormal, strange or inferior (Sue & Sue,

2003, Weaver, 2005). The values and standards of the helping professions are very much based on a Euro-American perspective, and as such might be inappropriate when working with clients from different cultural backgrounds (Sue & Sue). Moreover, when the approach used is based on these Eurocentric values, it could be perceived as paternalistic or pathologizing (Weaver). It is noteworthy that participants often spoke of their clients' culture as being the issue, but ignored their own. When cultural differences were mentioned, it was always comparing the clients' culture to the mainstream culture, which appeared to be the culture by default. Helping professionals need to actively seek to reduce ethnocentrism and prejudice in order to provide adequate services to culturally diverse clients. However, admitting that one has stereotypes about certain people groups is not an easy task. For a social worker to admit having prejudices and confronting fears and biases means letting go of the idea that one is a competent, unbiased professional (Weaver). Nonetheless, this is an essential step in order to provide culturally appropriate services to a diverse population.

The reaction described by a participant when explaining how difficult it was to address cultural and religious differences in a school setting is a clear example of how personal biases shape one's views of others. This participant may have felt that students praying in public were provocative because this is not the norm for her. However, for the young people in question, praying in public may have been the norm. The act that the participant described as being provocative could just have been a desire to continue with an accepted practice in the student's culture. Considering Quebec's Catholic history and the significant decrease of the role and influence of religion in Quebec society since the Quiet Revolution, it is not surprising that professionals working in a school setting would feel uncomfortable when religion is brought back to their secularized environment. The participant's personal worldviews and biases shaped how she perceived the clients and their behaviours and thus may have shaped her reactions and any recommended interventions. As Chahal (2004) noted, culturally diverse minority groups continue to be faced with mainstream services operating on the basis of stereotypes and erroneous assumptions. Nonetheless, the Code of Ethics of the

CASW (2005) clearly states that social workers must respect and recognize the diversity in our society and the rights of all individuals to their unique beliefs.

The notion of the culturally different client as being the 'other' is an example of how ethnocentric values and worldviews shape the perceptions that workers have of their clients. Several participants spoke of their clients as needing to adapt to their host culture. That is, they are in Canada and they need to adapt to the Canadian culture. However, Canada is supposed to be a multicultural society, and "multiculturalism is a fundamental characteristic of the Canadian heritage and identity" (Canadian Multiculturalism Act, 1985). Hence, one can assume that when participants spoke of adapting to the host culture, they were not speaking of the Canadian culture. They were in fact looking at their clients through their ethnocentric lenses and were referring to their own White, European-based culture. Moreover, it is interesting to notice that all but one of the participants who talked about the need for culturally diverse clients to adapt to the host culture identified themselves as French Canadian or Quebecois. It has been advanced that French-speaking social workers in Quebec might have a tendency to exert some assimilation pressure with their clients with different cultural backgrounds, given the "paradoxical context of finding themselves in a situation of being both a majority (in Quebec) and a minority (in Canada)" (Roy and Montgomery, 2002, p. 132). However, given the small study sample, one cannot make any generalizations on this topic and further research would be necessary.

Most participants recognized the fact that clients from different cultural backgrounds are constantly trying to arrive at a balance between their own culture, and what it encompasses of values, beliefs and traditions, and their host culture. The difference in the level of acculturation between parents and their children, as well as the different expectations regarding gender roles were often described as some of the sources of conflict for the clients. Participants tended to be more understanding of the children in these situations, who were exposed to the host culture and its different values in schools and with their peers. Their intervention goals appeared to be geared more towards them than the parents. This

is not surprising if one considers that they were evaluating and treating the problem from their ethnocentric worldviews, where the children were striving to become more like the norm and the parents were trying to stop them from doing so. Helping professionals may unconsciously be working from an assimilation perspective, where the clients need to relinquish their traditions and adopt the customs and lifestyles of the host culture (Weaver, 2005). Nevertheless, most participants acknowledged the resilience of their clients with different cultural backgrounds, who had to go through many changes and instability and still managed to function and find their strengths.

Conceptualization, challenges and facilitators of culturally competence practice.

Participants' definition of cultural competence comprised several elements found in the most used definitions in the literature, including awareness and knowledge about other cultures. These concepts were at times considered as challenging to fulfill by some participants, but other times they were viewed as facilitating the intervention process with clients from different cultural backgrounds. It is interesting to note that awareness of personal biases and prejudices was mentioned by all but one of the participants. This means that there is recognition of the impact of biases and preconceived ideas in the intervention process, and most agree that efforts need to be made for this not to interfere with the service delivery process. To be culturally competent, workers must be aware of their own biases and preconceived ideas about others' culture (Sue & Sue, 2003), but it also involves being aware of one's own ethnic identity and cultural background (Lum, 2007), a factor that was often absent from the participants' narratives. This is noteworthy as it illustrates that the cultural and ethnic identity of the mainstream population is seldom examined or questioned. The analysis of the data shows that this concept of being aware is not always practiced and participants' personal biases and prejudices still interfere in the intervention process.

One participant, while trying to demonstrate her efforts in preventing her personal views from interfering with her work with clients from different cultural backgrounds, mentioned that the client's cultural difference would not prevent her from intervening exactly in the same manner as with any other client. This brings us back to the notion of a colourblind approach, where the belief was that if one treated everyone in the same manner, services would be fair and just for all. Nevertheless, treating everyone the same and ignoring the client's cultural identity dismisses a significant part of that person's identity, which may lead to inappropriate and ineffective services (Weaver, 2005).

Although participants identified awareness of stereotypes and biases as an element in becoming culturally competent, this was also identified as a challenge. As Nathalie said, workers are human and it requires a conscious effort to avoid making assumptions and having prejudices and stereotypes. It can also become challenging when workers have different degrees of awareness of stereotypes and biases. Jackie and Dora both mentioned that there are still instances among workers where stereotypes play a role in the intervention process. For these workers, who appeared to be more aware of this issue than others, it was particularly challenging to witness their colleagues' stereotypical behaviours.

Furthermore, when discussing culturally competent practice, all participants mentioned knowledge about different cultures as being another essential element. Professionals working with clients from different cultures need to know about their clients' culture, including their values, beliefs and traditions in order to provide appropriate services to this population. It appeared that participants still adhere to the notion of culture as being something that can be summarized in a list of characteristics or traits common to all belonging to a specific group. They still view culture as something static and unchanging from person to person.

Nevertheless, cultural variations exist between different cultural groups, as well as within cultural communities, and when this fact is ignored, stereotypes and prejudices emerge (Este, 2007). When the emphasis is on understanding the

values and worldviews of members of different cultural groups, this implies that all members of these groups behave similarly (Weinrach & Thomas, 2004). However, cultural groups are formed by many different individuals, each with his or her own identity; therefore one cannot match an individual to an existing list of defined cultural characteristics and practices (Parrot, 2009). One participant expressed the idea that to become culturally competent involved being able to "master" all cultures, and she questioned the idea of ever attaining that goal, as there are so many different cultures to learn. However, one can never master a culture, as cultures are fluid and evolving (Carpenter-Song, 2007; Este, 2007) and cultures are not pure, static or monolithic (Pon, 2009).

Another element contained within the participants' definition of cultural competence involved the notion of clients being the experts in their own culture, thus workers need to access their knowledge. This parallels results from the study by Kwon (2009), where practitioners were regarded as learners rather than the experts. In Kwon's study, practitioners were encouraged to integrate cultural elements into their traditional practice, as well as explore and learn from their clients. Likewise, participants in the present study believed that considering clients as experts would facilitate and reinforce the therapeutic relationship. Furthermore, participants' open and respectful approach and attitudes with clients were believed to be conductive to a better intervention process. The challenge for some participants occurred when they saw the clients' expectations as unrealistic or impossible to be met, and it was necessary to avoid transferring their frustration to them. However, part of the intervention process should explore the reasons these clients felt entitled to some services.

Adapting to the client's reality was essential to provide culturally competent services. As Betancourt et al. (2003) explained, being culturally competent means understanding the importance of cultural impacts on the clients' health beliefs and behaviours, and devising their interventions in such a manner as these issues are taken into account. At the same time, this proved to be a challenge to accomplish in practice. When clients' understanding of the issue was clearly

framed by their cultural values and beliefs, as was the case when mental health issues were present, participants found it particularly difficult to adapt their interventions. Helping professionals are trained to work according to clearly defined intervention techniques, all based on theories and models developed with a Eurocentric perspective. Therefore, great efforts and personal work are needed to envision other explanations or solutions.

It is also noteworthy that the organization's role is increasingly seen as essential in providing culturally appropriate services. The focus is shifting away from the idea that cultural issues need only to be addressed at the practitioner-client level and towards a more structural analysis and inclusive service delivery system (Brach & Fraser, 2000; Graham, Bradshaw & Trew, 2010). It is at this organizational level that issues regarding inappropriate comments and acts towards culturally different colleagues and clients described by participants should be addressed and remedied. Participants felt that the organization needs to support and take an active role in the efforts of its workforce when providing culturally appropriate services. There would be little change if the organization employing these workers is monocultural and does not encourage their efforts (Sue & Sue, 2003), as services and practices are often a reflection of the organization's policies and guidelines.

Barriers and suggestions to improve culturally appropriate services.

Study participants identified several barriers to culturally appropriate service delivery. At the same time, they were able to provide creative suggestions that could improve practice with a multicultural population. Considering the context of multicultural interventions, the individuals exchanging information come from different cultural or ethnic backgrounds and this can have an impact in the communication process. Each person has his or her own communication style formed by personal worldviews, values, and attitudes, as well as different verbal and non-verbal codes. This can create an obstacle to the exchange of information, where one of the players in the communication encounter cannot understand the meaning of the other (Rheaume, Sevigny & Tremblay, 2000). Study participants

described the language difference with their clients as being one of the main barriers they encountered. Language differences made their work that much difficult, and this in turn created higher levels of frustration.

Communication is essential in order to establish a therapeutic relationship, as this is often based on an exchange of information and understanding. Helping professionals need to establish and maintain a strong therapeutic alliance in order for the intervention to produce the desired changes (Nichols, 2008). This means being able to listen and to acknowledge the client's point of view. However, when language is a barrier and the simplest of tasks (for example, calling to make an appointment) becomes a hindrance to building a relationship, the development of the therapeutic alliance is compromised. The use of translators can help address the language barrier. However, this brings about a different set of concerns and challenges. Building a therapeutic relationship and providing counseling through a third person can prove quite difficult, as several participants explained. As well, using informal translators, like family members, could result in ethical dilemmas regarding confidentiality and the existence of conflicts of interest (Bowen, 2001). Some of the suggestions for improving service delivery to a multicultural population involved having information and documentation available in different languages. Although this might alleviate some of the difficulties encountered due to the language barrier, they are not completely eliminated.

The lack of culturally accessible services was another barrier to culturally appropriate service delivery identified by the participants. For the purpose of this study, culturally accessible services refer to services in place that take into account the clients' values and worldviews, and where procedures and policies are such that they are conducive for adequate service provision to a multicultural population (Ducharme, Paquet, Vissandjee, Carpentier & Trudeau, 2007; Lai & Chau, 2007). When services are such that they can be defined as one-size-fits-all and clients are prevented from accessing them because of different cultural norms, this becomes a great barrier to request and receive services. For the participants in

this study, cultural accessibility was an integral element of culturally competent services.

Moreover, the perception that clients have of the helping professional can also become an obstacle in the intervention. One participant felt that clients did not trust her because she was not from their culture, and she was White. As previously mentioned, there is a history of mistrust of the White, Eurocentric social worker and the helping professional can be seeing by the client as being part of the problem instead of the solution (Iglehart & Becerra, 1996).

Some participants identified the lack of information about different services offered and of resources available as another barrier. This is similar as to what Ducharme et al. (2007) uncovered in their research. When the responsibility for finding out and accessing services is located with the clients themselves, this is illustrative of an institutionally racist approach to practice (Chahal, 2004). Hence, when workers feel that it is not their role or the agency's role to reach out to culturally diverse clients, as it was the case with one participant, this perpetuates the notion of institutional racism. Moreover, one participant mentioned that clients might have to deal with the stigma associated with looking for services outside of their family network or their community. Two other studies arrived at the same results, where feeling ashamed or uncomfortable with asking for help because of how they would be viewed by their community was identified as a barrier (Ducharme et al., 2007; Lai & Chau, 2007). Consequently, reaching out to cultural minority communities and introducing the services available to the multicultural population was one of the suggestions proposed by some participants who recognized this issue.

Participants saw the presence of professionals from different cultural or ethnic groups working in the organization as facilitating service delivery to a multicultural population and increasing their presence within the organization was seen as a suggestion to improving services. A lack of cultural diversity in an organization's workforce can translate into policies, procedures and service delivery methods that are not responsive to the need of a multicultural population

(Betancourt et al., 2003). Organizational objectives designed without the input of workers from different cultural backgrounds, who understand and consider different worldviews, can be incompatible with the real needs of clients (Graham, Bradshaw & Trew, 2010). Workers from minority groups can be a source of knowledge about their culture and can act as cultural experts to their colleagues. At the same time, clients appreciate being able to receive services from professionals who speak their language and know their culture (Brach & Fraser, 2000). In this manner, the workforce becomes more representative of the community it serves and services are seen as less mono-cultural (Chahal, 2004). However, it is unrealistic to expect a helping professional providing services to a multicultural community to be able to provide services to all clients in their own language, or by someone from their own culture in such a culturally diverse society as Montreal. Nevertheless, as one participant suggested, working alongside colleagues from different cultures can be more effective in fighting stereotypes and prejudices, as they begin to be more accepting and comfortable with differences.

Training on the subject of cultural issues was also a suggestion put forward by several participants as a means to improve service delivery. All participants deplored the lack of adequate training and support provided by the organization. Most found creative avenues to train themselves and look for what they considered the necessary knowledge to do their work. However, leaving the responsibility of professional development on individual workers alone, without a clear organizational vision, can translate into different quality of services being delivered as not all workers have the same interests and insights to make the necessary efforts for their professional development (Vega, 2005; Yamada & Brekke, 2008).

Study Strengths and Limitations

This study attempted to give a voice to the helping professionals working with a multicultural population, a research avenue that has not been usually addressed. However, one of its limitations was the sample size, as only nine

participants volunteered to be part of the study. The purposeful sampling strategy used is also a limitation, given that the researcher selected specific individuals to be part of this study. This type of sampling strategy was used in order to select individuals who could purposefully inform an understanding of the central issue of the study and were relevant to the research question (Creswell, 2007; Mason, 2002). Moreover, participants belonged to only three of the five programs offering psychosocial services. There are considerable differences between programs offered at the CLSC, depending on the target population and the specific needs that each program is addressing. This means that the realities of practice with clients with different cultural backgrounds might be different depending on the program accessed by the client. For example, the experiences of a professional working with the elderly population would be quite different than professionals working with new mothers.

Furthermore, the time constraint was a factor during the recruitment phase. Because there was no formal procedure at the organization where that study was done to request authorization, the researcher had to contact program managers to obtain his or her authorization to recruit their team members. However, one program manager only responded to the request several months later, which prevented members of that program from being recruited. Time constraints also prevented the researcher from conducting a follow-up interview with participants, which would have provided an opportunity to expand from their initial responses. Nevertheless, member checking was done via email by having the participants review their responses and having an opportunity to make corrections or additions, which increased the reliability of the interpretations. In addition, policy and procedure documents from the organization were reviewed as an additional source of data.

Considering that the sample was drawn from a particular CLSC located on the island of Montreal, the multicultural population it serves cannot be regarded as representative of other areas. Furthermore, the findings are drawn from the personal experiences of helping professionals in this setting. Therefore, findings

from this study are not meant to be generalized to other settings but could inform researchers and practitioners interested in the issue of culturally relevant services.

Another limitation was that, due to time constraints it was not possible to pilot test the questionnaire. However, the interview questionnaire was based on issues described in the literature regarding work with clients with different cultural backgrounds. Moreover, given that it was a semi-structured interview protocol, this provided some flexibility during the actual interview process to adapt and accommodate to the participants' responses as they emerged.

Finally, the researcher's position as a co-worker might have affected or influenced the participants' responses and the data analysis. Although efforts were made to ensure the impartiality of the study, the fact that participants had a previous working relationship with the researcher might have had an impact in their responses. They might have, consciously or unconsciously, modified their answer in order to comply with what they thought was expected or acceptable.

Implications for Policy, Practice and Future Research

There are several implications for policy and practice resulting from this study. First, although most participants acknowledge the idea that personal biases and preconceived ideas influence the intervention process, there is still a need to acknowledge when this occurs in practice, as the results demonstrated that these are in fact interfering in service delivery at times. Professionals need to be supported and guided in their endeavors to become aware of their own biases. This process could occur through supervision or team discussions. For this to happen, the organization needs to develop and enforce a clear policy on cultural issues when providing services to a multicultural population. Presently, there is no such policy in the agency where the study was performed; therefore, this should be one of the main priorities if culturally appropriate services are to be available.

Second, there needs to be a shift in emphasis away from a knowledge-based cultural expertise model towards a greater focus on clients as individuals. In order to provide culturally appropriate services, professionals need to engage with

the cultural differences of their clients. They need to embrace the idea that culturally diverse clients cannot be categorized and that one must be open to learning from the client. As a similar study done with health practitioners revealed, instead of assuming cultural knowledge of the clients, professionals need to ask them about their views and what matters most to them (Kai, Beavan, Faull, Dodson, Gill, & Baighton, 2007). Again, the organization has an important role to play by supporting its employees in this process and providing the necessary training and resources to do so, as well as clearly stating its vision in this regard.

Finally, services need to be adaptable to the clients' realities and procedures need to be flexible to ensure culturally accessible services. The colourblind approach where one model fits all is not appropriate when working with a culturally diverse population. Therefore, services need to be able to meet the clients' needs instead of requiring that the clients adapt to the services offered. As suggested by some participants, organizations need to reach out to these vulnerable clients in order to provide better services.

In terms of future research, this study only explored the point of view of front-line professionals working with clients with different cultural backgrounds in a particular setting. It will be necessary to explore this reality in different settings in order to study similarities and divergences according to the different populations accessing services. At the same time, research would need to be done where the opinions and experiences of the actual clients from different cultural backgrounds are explored. The clients accessing services are the only ones in a position to determine if the services are culturally appropriate or not.

Given that all participants expressed a need for training on the subject of cultural issues, the organization would need to develop a policy on professional development that would include a section on practice with multicultural populations. Possible ongoing training options could include the lectures provided by the Canadian Council for Refugees, the trainings on intercultural practice offered by the Research and Training Centre at the CSSS de la Montagne, or the

conference series on intercultural relations offered by the Association Canadienne pour la Santé Mentale (ACSM). The goal of these trainings would be to address the challenges and issues associated to the interventions with culturally diverse communities.

For example, a recent conference offered by the ACSM on the intervention process with families from Asian origins illustrated how some clients' spiritual beliefs and worldviews played a crucial role in the intervention process when dealing with issues of mental health. Therefore, training must address the need to learn more about the different clients' worldviews and how their culture, beliefs and values shape their vision of the world. Training for professionals working with families would include how the immigration process impacts family dynamics and roles, as well as its effects on the individual person. The different acculturation levels between family members also need to be understood and negotiated, and this requires professionals to be aware of such differences. At the same time, training must address the professionals' own cultural identity and the way their worldview shapes how they envision the intervention process.

It would be interesting to evaluate how such training shapes the quality of service delivery. Some studies have suggested that training improves the knowledge, attitudes, and skills of health professionals, but there is a lack of evidence linking training to clients' adherence to treatment, better outcomes or equity of services across cultural groups (Beach et al, 2005; Yamada & Brekke, 2008). Further research would need to evaluate how training can improve services delivery and outcomes, as well as what types of training are more appropriate in giving the desired results.

Appendix A: Invitation to participate in a research project

Title of research: The impact of culture and ethnicity in psychosocial work.

Researcher: Sonia Cisternas, Master's Student at McGill School of Social Work

Supervisor: Dr. Nicole Ives, assistant professor at McGill School of Social Work

You are invited to participate in a research study on the impact of cultural background and ethnicity on psychosocial interventions provided to a culturally diverse population. The purpose of this study is to examine the impact of ethnic and cultural differences in service provision in the context of a government agency providing services to the community. It will explore the practitioners' perception of what cultural competence means in practice and the possible challenges, barriers and facilitators encountered by workers in this context. Data will be collected through individual interviews with practitioners working with a culturally diverse population at the CLSC Pierrefonds. Participation will be voluntary and all necessary measures will be taken to protect participants' confidentiality. Participation in this research project will permit to reveal important stakes in services delivery and the results will be presented to interested participants as well as to the West Island HSSC direction.

For any additional information or if you wish to participate in this research project you can contact Sonia Cisternas at sonia.cisternascid@mail.mcgill.ca or by phone at 514-425-6085.

Thank you for your collaboration.

Appendix B: Invitation à participer à un projet de recherche

Titre du projet de recherche : L'impact de la culture et l'ethnicité dans les interventions psychosociales

Chercheure : Sonia Cisternas, étudiante à la Maitrise en Travail Social, Université McGill.

Superviseure : Dr. Nicole Ives, professeure a l'école de travail social, Université McGill.

Vous êtes invites à participer à un projet de recherche sur l'impact de la culture et l'ethnicité dans les interventions psychosociales offertes a une population multiculturelle. Le but de ce projet est d'étudier l'impact des différences ethnoculturelles dans l'offre des services dans le contexte d'un organisme gouvernemental ouvrant dans la communauté. Il examinera la perception des intervenants quant a la signification de la compétence culturelle dans la pratique et les possibles défis, barrières et solutions rencontrés dans ce contexte. Les données seront recueillies à partir d'entrevues individuelles avec des intervenants travaillant avec la population multiculturelle du CLSC Pierrefonds. La participation à cette étude est entièrement volontaire et toutes les mesures nécessaires seront prises afin de sauvegarder la confidentialité des participants. La participation à ce projet de recherche permettra de mettre en lumière des enjeux importants dans l'offre de services et les résultats obtenus seront présentés aux participants intéressés et à la direction du CSSS de l'Ouest de l'Ile.

Pour toute information additionnelles ou si vous désirez participer à cette étude veuillez contacter Sonia Cisternas a l'adresse courrielle sonia.cisternascid@mail.mcgill.ca ou en téléphonant au 514-425-6085.

Merci pour votre collaboration.

Appendix C: Interview Guide

Demographic data

1- Age of participant
2- Gender
3- Years of experience
4- Ethnic or cultural background of participant
5- Level of education

Worker's own experiences with ethnic/cultural minorities

1- Have you had any experience working with a multicultural population?
2- What was the nature/context of your intervention with these populations?
3- Can you tell me about your experience working with multicultural populations?
4- What did you find most challenging?
5- What did you find most interesting?
6- Did you have access to an interpreter or a cultural consultant?
7- If so, how did you find the experience?
8- How would you define cultural competency?
9- What needs to be done to improve service delivery to a multicultural population?

Existence and usefulness of appropriate training

1- Have you had any training specifically on issues of cultural diversity?
2- If so, where did you get this training?
3- How would you evaluate the training received?
4- Were the concepts learned reinforced afterward through supervision, case discussions, or in any other way?
5- Do you have any recommendations regarding the availability and relevance of the training received?

Possible barriers and/or facilitator encountered

1- What were the main barriers during the intervention process from your perspective?
2- Did you receive any support during the intervention process in order to eliminate or decrease these barriers?
3- What were the main facilitators during the intervention process from your perspective?

Final question

Are there any additional comments or observations regarding your experience intervening with a culturally diverse population that your would like to add?

Appendix D: Guide de l'entrevue

Données démographiques

1- Age du participant
2- Sexe
3- Années d'expérience
4- Groupe culturel ou ethnique du participant
5- Niveau d'éducation

Expérience de l'intervenant avec la population multiculturelle

1- Avez-vous de l'expérience travaillant avec une population multiculturelle?
2- Quelle était la nature/contexte de ces interventions?
3- Pouvez-vous me parler de votre expérience de travail avec une population multiculturelle?
4- Quels défis avez-vous rencontres?
5- Qu'avez-vous trouvé intéressant?
6- Avez-vous eu accès a un traducteur ou un consultant culturel?
7- Si oui, comment avez-vous trouvé votre expérience?
8- Que veut dire pour vous la compétence culturelle?
9- Que doit-on faire pour améliorer l'offre des services a la population multiculturelle?

Disponibilité et utilité de formations appropriées

1- Avez-vous reçu des formations concernant les problématiques reliées à la diversité culturelle?
2- Si oui, ou avez-vous reçu cette formation?
3- Comment évalueriez-vous cette formation?
4- Les concepts appris ont-ils étés renforces par après dans des supervisions, discussions des cas ou d'autres façons?
5- Avez-vous des recommandations concernant la disponibilité et la pertinence des formations reçues?

Barrières et facilitateurs possibles

1- Quelles ont étés les barrières rencontrées dans le processus d'intervention selon votre opinion?
2- Avez-vous reçu du soutien pendant le processus d'intervention afin d'éliminer ou réduire ces barrières?
3- Quels ont étés les facilitateurs principaux pendant le processus d'intervention selon votre opinion?

Question finale

Avez-vous des commentaires additionnels concernant votre expérience dans l'offre de services à une communauté multiculturelle?

Appendix E: Research Consent Form

McGill University

Title of research: The impact of culture and ethnicity in psychosocial work.

Researcher: Sonia Cisternas, Master's Student at McGill University School of Social Work

Contact Information: sonia.cisternascid@mail.mcgill.ca

(514) 398-7065

Supervisor: Dr. Nicole Ives

You are being asked to participate in this interview, which forms part of the research study on the influence of cultural background and ethnicity on psychosocial interventions provided to a culturally diverse population. The purpose of this study is to explore the impact of ethnic and cultural differences in service provision in the context of a government agency providing services to the community, as well as to explore the practitioners' perception of what cultural competence means in practice and the possible challenges, barriers and facilitators encountered by workers in this context. Data will be collected through individual interviews with practitioners working in the field with a culturally diverse population.

The potential benefits of this project will be to help understand how changes in the composition of a certain population, in this case the increased cultural and ethnic diversity in the area serviced by the CLSC Pierrefonds, may have an impact on the interventions and the experiences of the practitioners in the field. Moreover, challenges, barriers and facilitator elements will be identified, which could in turn be used to adjust already existing practices and policies or to develop new ones. There are no foreseeable risks of participation, as neither the employer nor the supervisors will know who chose to participate or not in this research. The results of this research project will be disseminated in the form of a thesis and as presentations to the personnel of the CLSC.

Your involvement is purely voluntary and in accepting to participate in this research project you agree to an oral interview, lasting about one hour conducted by the researcher. The interview will take place at the CLSC Pierrefonds or at a location outside of the workplace to be determined according to your preference. The audio recordings of the interview will be used for transcription purposes only. You have the right to speak off the record, and what you say will not be used. You can choose not to answer any questions. You may withdraw from the research at any moment and ask that your portion of the interview be excluded from consideration.

The audio recorded interview will be transcribed and all identifying information about yourself or others will be removed before storing it. The interview recordings and transcripts will be labeled with numbers to be referred throughout the research to avoid nominative information. A master list linking case numbers and names will be created and stored separated from all data. Only the researcher and Dr. Ives will have access to the master list. The audio files, the transcripts and master list will be kept locked in a safe and secure place (password encrypted computer and the physical notes will be kept in the locked office of Dr. Ives). Your name or identity will not be revealed in any publication, and no information that is revealed will be treated in such a way that you are identifiable. The audio files will be deleted after a period of six months. The transcripts will be stored in the locked office of Dr. Ives for a period of 5 years, and then they will be destroyed.

At the end of the study a report will be published and you will receive a copy if you choose.

If you have questions about your rights as a research participant in the study, you can contact Lynda McNeil, Research Ethics Officer, McGill University at (514) 398-6831.

Your signature below serves to signify that you agree to participate in this study.

You agree to have the interview audio recorded

___ yes

___ no

There are two copies of this consent form, one of which you may keep. The other signed consent form will be kept secure in a locked cabinet in Dr. Ives' locked office.

Thank you for your participation.

______________________ ______________________ ____________

Name (or initials) Signature Date

______________________ ______________________ ____________

Interviewer Signature Date

Appendix F: Formulaire de consentement

Université McGill

Titre du projet de recherche : L'impact de la culture et l'ethnicité dans les interventions psychosociales

Chercheure : Sonia Cisternas, étudiante à la Maitrise en Travail Social, Université McGill.

Information: sonia.cisternascid@mail.mcgill.ca

(514) 398-7065

Superviseur: Dr. Nicole Ives

Vous allez participer à cette entrevue, qui fait partie d'un projet de recherche sur l'impact des différences ethnoculturelles sans les interventions psychosociales offertes à une population multiculturelle. Le but de ce projet est d'étudier l'impact des différences ethnoculturelles dans l'offre des services dans le contexte d'un organisme gouvernemental ouvrant dans la communauté, en plus d'examiner la perception des intervenants quant a la signification de la compétence culturelle dans la pratique et les possibles défis, barrières et solutions rencontrés dans ce contexte. Les données seront recueillies à travers des entrevues individuelles avec des intervenants travaillant avec une population multiculturelles.

Les bénéfices potentiels de ce projet seront d'aider à mieux comprendre comment des changements dans la composition d'une population, dans ce cas l'augmentation de la diversité ethnoculturelle dans le secteur desservi par le CLSC Pierrefonds, peut avoir un impact dans les interventions et les expériences des intervenants. En outre, les défis, barrières et les éléments facilitateurs seront identifies, ce qui permettrait d'ajuster les pratiques et procédures déjà existantes ou d'en développer des nouvelles. Il n'y a pas de risque prévisible à votre participation, puisque ni l'employeur ni les superviseurs sauront qui a choisi de participer à ce projet de recherche. Les résultats de ce projet de recherche seront disséminés à travers un mémoire écrit et des présentations au personnel du CLSC.

Votre participation est entièrement volontaire et en acceptant de participer à ce projet de recherche vous acceptez une entrevue oral, d'approximativement une heure, menée par la chercheure soussignée. Cette entrevue aura lieu dans le CLSC Pierrefonds ou ailleurs selon vos préférences. L'enregistrement de l'entrevue sera utilise seulement pour la transcrire. Vous avez le droit de demander que ce que vous dites ne soit pas inclus et ce que vous direz ne sera pas utilise. Vous pouvez choisir de ne pas répondre à toute question. Vous pouvez mettre fin à votre participation au projet de recherche à tout moment et demander que votre entrevue soit exclue des analyses et résultats;

L'entrevue enregistrée sera transcrite et toute information qui pourrait vous identifier sera exclue. Les enregistrements et transcriptions des entrevues seront

identifies avec des numéros. Seulement ces numéros seront utilises lors de la recherche afin d'éviter d'utiliser des informations nominatives. Une liste sera créée liant ces numéros aux noms des participants et elle sera entreposée séparément de toute autre donnée. Seulement la chercheure et la Dr. Ives auront accès à cette liste. Les dossiers audio, la liste des noms et les transcriptions des entrevues seront conservés dans un endroit sécuritaire (les données audio seront conservées dans un ordinateur protégé par mot de passe et les transcriptions seront conservées sous clé dans le bureau de la Dr. Ives). Votre nom ou identité ne seront révélés dans aucune publication, et toute information utilisée sera traitée de sorte qu'elle ne soit pas identifiable. Les données audio enregistrées seront détruites après 6 mois. Les transcriptions des entrevues seront conserves dans le bureau de la Dr. Ives pour une période de 5 ans, et elles seront détruites par après.

A la fin du projet de recherche un rapport sera publie et vous en recevrez une copie si vous le désirez.

Si vous avez des questions concernant vos droits comme participant a cette étude, vous pouvez contacter Lynda McNeil, officier de l'Ethique de la Recherche, Université McGill, au (514) 398-6831.

Votre signature signifie que vous acceptez de participer dans ce projet de recherche.

Vous acceptez que votre entrevue soit audio enregistrée

___ oui

___non

Il y a deux copies de ce formulaire de consentement, une que vous pouvez garder pour vous. L'autre copie de consentement signée sera conservée sous clé dans un classeur dans le bureau de la Dr. Ives.

Merci pour votre participation.

______________________ ______________________ ____________

Nom (ou initiales) Signature Date

______________________ ______________________ ____________

Chercheure Signature Date

Appendix G: Code List

Impact of clients' culture
- Dealing with cultural differences
- The notion of the "other"
- Workers' perceptions of clients with different cultural backgrounds

Participants' conceptualization of cultural competence
- Being aware
- Knowledge about different cultures
- Clients as experts
- Workers' approach
- Role of the organization in promoting culturally appropriate services

Barriers
- Accessibility
- Clients' perception of the helping professional
- Lack of information and resources
- Language

Challenges working with a multicultural population
- Adapting to clients' reality.
- Clients' expectations
- Being a resource worker.
- Stereotypes and misconceptions

Facilitators in the intervention process
- Attitudes
- Culturally diverse workers

Training and support for professionals
- Availability and need for training
- Being self-taught
- Absence of support and structure

Suggestions for improvement

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