In Praise of Cultural-Competence Training for Mental Health Professionals

Julia Mirsky, PhD

Department of Social Work, Ben-Gurion University of the Negev, Beer Sheva, Israel

ABSTRACT

Background: Mental health practitioners in Israel encounter clients from a variety of ethnic groups and cultural backgrounds. Yet, culturally-informed practice standards have neither been defined nor promoted by the professional establishment. **Method:** A model for cultural-competence training for mental health professionals is presented and evaluated based on self-reports of 51 trainees. **Results:** An increase in the trainees' understanding of their clients' cultural experiences is elicited, as well as the expansion of their cultural self-awareness, empathy and respect for cultural diversity. **Limitations:** This is a qualitative evaluation with a limited number of respondents and provides data only on short term effects of the training. **Conclusions:** The evaluation demonstrates positive training effects on the practice. Hopefully, this experience will encourage addressing cultural issues in the practice and training of mental health professionals in Israel.

In recent decades, with migration becoming a worldwide phenomenon, mental health practitioners in many Western countries encounter a growing cultural and ethnic diversity among their clients. Accordingly, mental health practitioners have recognized that cultural competence is essential to their practice.

Canada is an example of the most progressive country regarding attitudes towards cultural competence, as reflected in the 1971 Canadian Multiculturalism Act. A variety of cultural training programs in mental health are offered by public and academic organizations throughout this country (1). Many such programs also exist in Australia, e.g., the Multicultural Mental Health Australia (MMHA) is a national program to improve awareness of mental health and suicide prevention in its culturally and linguistically diverse communities. Also, major mental health professional organizations in the United States took action to promote such a competence among their members. The recognition of the American psychiatric establishment regarding the importance of providing culturally-responsive clinical conceptualization, assessment and treatment is represented in the inclusion of the Cultural Formulation (CF) of Diagnosis in Appendix IX of the DSM-IV (2). The components of cultural formulation are, among others: the patient's cultural identity, cultural significance of symptoms and behaviors, cultural explanations of illness and overall cultural assessment for diagnosis and treatment. Developed by an international team, the CF is being researched and disseminated around the world (3-6). Similarly, the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists,* formulated by the American Psychological Association, provide a context for culturally-sensitive service delivery (7). Psychologists are encouraged to apply culturally appropriate skills in their practice, as well as to develop practices attuned to the unique worldviews and cultural backgrounds of their clients.

The American National Association of Social Workers (NASW) has published Standards of Cultural Competence that recommend social workers to strive to deliver culturally-competent services (8, 9). Under the current Education Policy and Accreditation Standards of the Council on Social Work Education, students are to be taught how to define, design, and implement strategies for effective practice with persons from diverse backgrounds (10).

Address for Correspondence: ✉ Ben-Gurion University of the Negev, POB 653, Beer Sheva, Israel 84105 juliamirsky@gmail.com

A wide diversity typifies European countries in their recognition of the importance of cultural competence in mental health. However, European or national comprehensive policies are lacking in this respect. While northern-European and traditionally migrant-receiving countries such as the United Kingdom have a more developed approach to cultural competence training, southern-Mediterranean countries have just recently recognized the need for such training. Lack of attention to cultural issues in practice and policy is noticeable in eastern European countries (11).

The persistent endorsement of cultural competence in the mental health professions, mostly in North America, led to the development of a variety of models for cultural-competence training. These models share the understanding that three basic elements are the perquisite for effective cross-cultural practice: cultural awareness, cultural-specific knowledge and skills (5, 12-14). However, they differ in their conceptual foundations and in the strategies used to attain these goals. Cultural training models in the field of mental health may be based on the approach of social constructivism (13) or the notion of cultural empathy (15) as well as the Cultural Formulation (16). They implement a myriad of different training techniques, such as didactic approaches (17), structured exercises (18), narrative analysis (19), experiential learning (16, 20) or cultural immersion (21).

Despite the abundance in cultural competence training models, there is surprisingly little data on their effectiveness. A recent systematic review of models for cultural competence training in the health professions identified that out of 109 publications that presented such models, only nine, and all from the U.S., included an evaluation (22). The findings generally indicate positive effects for cultural training (6, 23, 24). However, only currently, the first steps were taken towards the development of a more systematic approach to evaluating cultural competence training programs (25).

To sum up, there is a growing understanding that mental health services need to be more culturally attuned. Although cultural competency has been defined in many different ways, the widest common conceptualization is that it comprises knowledge, awareness and skills with regard to the differences and similarities between the culture of the client and the mental health professional.

Although Israel is typified by an almost constant influx of new immigrants and numerous ethnic groups, little has been done in the country to promote culturally-sensitive practice or mandate the inclusion of cultural training in the educational curricula of mental health professionals. Only recently, the importance of providing culturally-sensitive care was acknowledged with the Ministry of Health's call for action (26). On the individual level, numerous practitioners and researchers working in Israel integrate cultural components in their work (27-40). Yet, no collective and systematic effort has been made to formulate standards for culturally-informed practice and training in the field of mental health.

This paper hopes of contribute to this effort by raising the awareness to the need and feasibility of cultural-competence training in Israel. It presents a successfully applied training model for cultural competence and the results of an evaluation study of the effects of this training. This paper illustrates the application of the training model to the encounter of practitioners from the majority group (i.e., Jewish Israeli natives) with Jewish immigrant clients. However, its principles and techniques can be applied to culturally-competent practice with clients from other minority groups in Israel, and in other countries.

THE TRAINING MODEL

AIMS AND RATIONALE

The training model being evaluated in this paper has been described in detail in an earlier publication (41) and will be presented here briefly. Its primary aim is to help students develop empathy towards clients from various cultural backgrounds, and especially to those whose background is different than their own. In the present context, attention is devoted to becoming aware and attuned to the clients' experiences as immigrants, as newcomers to a foreign culture and/or as members of a minority group. An attempt is made to educate clinicians to adopt a humble stance that takes into account their own subjectivity and cultural biases and keeps them under continuous self-scrutiny. The training model also underscores the importance of cultural information and culturally-attuned skills. It offers some information on major ethnic groups in Israel and encourages ongoing cultural knowledge-seeking and skills development.

Two assumptions dictated the techniques implemented in the model to achieve those aims: First, personal narratives are a major source of information and knowledge about the experience of people in different cultures. Because they are flexible and narrator-oriented, narratives can contain unique cultural materials and help trainees become more aware of the uniqueness

of each culture, as well as of the specific expressions of universal values and personal characteristics in different cultures (42, 43). The analysis of narratives is based on the notion that sense-making is an interactive human activity (44). When trainees are active participants in the sense-making process, learning may result in greater self-awareness, which may become the ground for greater empathy and sensitivity to the other (19). This assumption is the basis for the use of narratives and narrative analysis in the training model.

Second, cultural training comprises not only the acquisition of knowledge and skills, but also emotional learning and self-awareness. The encounter with clients from a different culture, whose experiences as immigrants, refugees or members of a social minority are unfamiliar to Western practitioners, may stir in them a myriad of intense, often unconscious, emotions. Unconscious resistance against the awareness of these experiences may obstruct the learning process (43). Therefore, to clear the way for the acquisition of knowledge and skills necessary for culturally-competent practice, a training model needs to address unconscious resistance, attitudes and beliefs of the trainees, and develop their self-awareness and empathy towards the "other." This assumption leads to the use of the group process.

SETTING AND TECHNIQUES

The training model is implemented in a course that has been taught by the author for the past seven years in the Master's program of Social Work at the Ben-Gurion University. It is an elective course open to MA and PhD students in Social Work and Psychology, and is most often attended by students currently working in the field of mental health or those interested to become mental health professionals. The course consists of 48-50 academic hours offered over one or two semesters with weekly sessions. On average, 24-26 students participate in the course yearly.

The course combines two interweaving elements. First, presentation and discussion of scientific articles on psychological aspects of migration. Second, an analysis of immigrant's narratives. The scientific materials include the state of art theoretical and research articles on individual and family processes in migration, stress, coping strategies and psychopathology, as well as clinical papers on interventions with clients from diverse cultural backgrounds and on counter-transference with such clients. The narratives are collected by students through in-depth, unstructured interviews with people who experienced migration or cultural transition. Typically, students interview their friends, neighbors, co-workers and relatives. To avoid the effect of pre-existing relationships on the interview, students are encouraged to interview the friends or co-workers of other students. The interviews are tape-recorded and transcribed. Each student submits a paper based on the analysis of the narrative of his/her interviewee and the relevant literature. Some students also present their interviews in class. This is followed by a class discussion, with of the course instructor acting as a facilitator.

GAINING EMPATHY – THE GROUP PROCESSES

The following process extracts illustrate how the group work helps the participants gain empathy towards the interviewees:

VIGNETTE 1

Gregor, a 67-year-old man, immigrated to Israel from Yugoslavia as a child, a number of years after World War II. Upon arrival, his parents sent him to a boarding school, where he was the youngest in his group. There he became the target of mockery and bullying. He succeeded in becoming a "model Israeli" and in erasing his past: *"I don't remember anything from before the age of 12, my memory starts when we got to Israel."* Gregor told his story in a dry tone and a number of times repeated: *"I have no hard feelings."*

The interviewer was very emotional when he presented the narrative in class.

He was surprised at his own reaction because during the interview with Gregor he was not that moved. Similar reactions followed from other students. They captured the covert sadness of Gregor, his denial of it and his determination to cope at any cost. Explorative group process allowed uncovering the emotions that accompanied Gregor's adjustment as an immigrant, emotions of which he himself was not aware. The insight that the participants, including the interviewer, who had known Gregor for many years, gained into Gregor's denied emotions made it possible for them to feel more empathy towards him.

VIGNETTE 2

Diana, 30, married with two children, emigrated from the former Soviet Union in her late teens. Her mother abandoned her in childhood and she was raised by her maternal grandparents in a city distant from where she was born. Following the war in Chechnya, the family fled to another region and then to Israel. Her elderly grandparents died a

few years after they arrived and she remained alone. For a number of years Diana supported herself by selling her body to men and earned a lot of money. After having been seriously injured in a car accident, she decided to change her lifestyle. Presently, she pursues a successful career and raises a family. However, she does not feel she belongs in Israel and appears emotionally detached.

The following discussion took place in class after Diana's interview was presented:

(MU): This is the saddest story we have heard this year.

(SA): Nothing ties her to anywhere

(AA): So horrible, a child abandoned by her mother

(OH): The detachment is very obvious: one is born in one place, lives in another, dies in yet another…

(TA): Terrible things happen to her all the time, they just drop on her and there is nothing she can do, sometimes only flee.

(SA): Yes, she is detached, feels nothing, loves no one. And she has everything, a family, children, a home. But she feels differently.

(Facilitator): Maybe this is how she feels because many of the things she used to have were "taken" from her - by chance, by accident - things that are important to her she loses.

(AA): She had her body, this could not be taken from her and she could sell it and get money.

(YK): She did not have much choice but to sell her body.

(AA): It was not a free choice.

(MR): My grandmother went through the Holocaust, it was worse, and she did not… It annoys me when you say "she did not have a choice." She chose to be detached and miserable, she keeps choosing that.

(AL): She is not miserable, she is detached.

(Facilitator): It is important to try and understand what is annoying in Diana's story.

(MR): I am sorry, I was being judgmental, but…

A fervent discussion arose in class as to whether she did or did not have a choice and I, the facilitator, interpreted this as a sign of difficulty and resistance:

(Facilitator): Perhaps it is difficult for us to realize, that although we have choices, there are also constraints in our lives. The personal assets that we possess determine our choices, especially in stressful situations. Her personal assets and external conditions considered, Diana must have made the best choices she could possibly make.

(SA): Yeh, she is a very strong woman. I don't know how I would have coped in her place…

Others nodded in agreement.

THE EVALUATION STUDY

The following is qualitative evaluation study that was performed two months following the termination of three consecutive courses.

Respondents. The respondents were 51 students from three academic years, representing between 70% and 85% of all students who participated in the course each academic year. Most students (80%) in the evaluation study were women and this reflects the gender profile of social work students as well as practitioners. Most (80%) were in their late twenties to early thirties, with only few exceptions (two students were aged 47). One-fourth (25%) of the students were foreign-born, all from the former Soviet Union. Half (50%) were second generation immigrants [although they did not initially identify themselves as such but rather as "*Sabra*"]. One-fourth (25%) of the respondents were third or fourth generation, among them six Arab and Bedouin students.

Data collection. The students were asked to submit a short account (200-500 words) of their personal experience in the course (an elective assignment). The instructions were as follows: *"Please, relate to your personal experience in the course: Your experiences in the interview; How did your participation in the course affect your attitudes towards clients from diverse cultural backgrounds? Towards yourself? These are merely general guidelines. Feel free to share whatever you find significant."*

The accounts of 51 respondents who submitted this elective assignment comprised the data of the qualitative evaluation. These accounts were submitted about two months after the end of each course.

Data analysis. The contents of the accounts were analyzed by the author via a holistic method (45). First, all accounts were read several times with the aim of obtaining a general orientation on the presented contents. "Open coding" applied in the next round of reading, made it possible to code central themes within each of the accounts, and accompany them by citations from the account. In the next readings, themes that reoccurred in several accounts were identified. Then "axis coding" was applied: the recurring themes were defined more precisely and more clearly differentiated from each other. The final reading of all accounts made it possible to fine-tune the themes and select the most illustrative citations.

Findings. The following findings relate to the cognitive outcomes of the training – What information did the students acquire in the course? What did they learn? -

and to practical outcomes – How did this learning affect the students' practice? These two outcomes emerged as central themes in data analysis. An additional theme, the personal and emotional outcomes of the training, is not addressed here due to lack of space. Extracts from representative accounts by respondents accompany presentation of major themes.

A. Cognitive outcomes of training

All respondents related in their accounts to the fact that they gained significant knowledge in the course. Many did that through general statements such as "I gained a lot of knowledge about migration in the course" or "the course contributed to my understanding of immigration and immigrants." Also, 26 respondents (51%) related to this issue explicitly and in detail. The knowledge\understanding they referred to can be grouped into three categories:

A.1. Understanding of the significance of the experience of migration

Most striking in the accounts was the fact that only following the course did many of the respondents begin to understand how significant the experience of migration may be in a person's life. In the words of one of the respondents - "how present" it is.

(OH) I take with me the appreciation that immigration is a dramatic life situation that destabilizes the emotional balance in all spheres of life, and that it should be taken very seriously.

(TA) Now, I understand better the power of the experience of migration. It is an important and significant event in the life of a person. It influences the person's future life and is an inseparable part of his/her personality, of the way the person deals with the natural and common tasks of life.

A.2. Understanding of the universal psychological nature of migration

Many respondents reported that they gained an understanding that they did not have before about the psychological processes that occur during migration and cross-cultural transitions:

(AA) I learned about the impact of migration on the individual and the family, and of how important it is to understand it.

(YK) I gained new insight into the processes of migration on the theoretical level, mainly psychological – about processes that are universal and that immigrants experience them wherever they are.

Even respondents who underwent migration gained deeper insights into the impact of migration:

(MU) My participation in the course made me very much aware, which I was not before although I am an immigrant and came to Israel 20 years ago, to the multiple meanings and complexities of migration.

Most of the respondents stressed their newly gained awareness of the negative implications of migration:

(SZ) … the difficulties immigrants have: the difficulty to get used to a new culture, the mourning of what has been left in the homeland, the question of belonging: to which country do I belong now?

(AL) … I learned to understand that the transition from one country to another, even if it was voluntary and driven by ideals, may be very difficult.

(TH) The course helped me to understand how immigration difficulties may add to the normative stresses of adolescents and render adolescent immigrants at special risk.

However, some respondents managed to develop a more balanced view of the impact of migration:

(LP) … the experience of migration is complex: it is exciting, interesting, challenging but also frightening, worrying and stressful.

(MB) I came out with the understanding that migration is a universal event that holds unique difficulties as well as unique opportunities.

A.3. Understanding the uniqueness of the experience of migration

Along with the understanding of migration as a universal psychological process, the respondents emphasized the individual diversity and unique quality of each person's migration experience.

(RM) There is not one constant process that each immigrant goes through and there is not one narrative with similar main themes that all immigrants have.

(SA) I understand how the process of immigration is on one hand common to many immigrants. But, how on the other hand, it is very personal and differs in each family. Most immigrants experience more or less similar events that have to do with migration: low status and low paid jobs, learning a new language, moving from one rented apartment to another. But each immigrant arrives with different assets, material and emotional.

(AA) The experience is different and unique for each individual…. I understand now the decisive impact of personal and psychological assets in the process of

migration. …. the importance of the psychological personality structure of the immigrant, of family relationships, of the age of migration. These factors decide whether the outcome will be a success or a failure.

B. Effects of training on practice

Perhaps, because all students in the course were working in the field, more respondents related in detail to the implications of the course to their practice than to purely cognitive outcomes of the training. In addition to general statements such as "the course changed my attitude to clients" or "I feel that my practice with immigrant clients will be better now," 29 respondents (57%) provided detailed accounts of the effect the course had on their practice.

B.1. Exploration of the migration experience with clients

The cognitive understanding that migration has important and long-term implications in all spheres of individual life was translated by many of the respondents into a special attention to this issue in their professional practice. They kept the importance of this experience in mind and encouraged their clients to talk about it:

(ST) I give space to my client's immigration story even if immigration took place long ago and seems not to be related to his/her present condition.

(AR) The course taught me that we need to make it possible for our clients to get in touch with their pain and their unpleasant memories, but also become aware of the growth and other things they gained because of immigration.

The following clinical vignette provided by one of the respondents vividly illuminates this outcome.

(MB) Working in an emergency center for children at risk I was treating a 33-year-old woman whose son was placed in the center. This client had immigrated to Israel when she was 14. As I got to know her better, parallel to taking the course, I started to appreciate the heavy weight of immigration in her development … and the scar she was still bearing from that time. She was reluctant to talk about the crises she experiences as an immigrant, wanted to "let bygones be bygones" and was eager to "belong," to be "an Israeli." I could have easily avoided the issue, like she wanted, had I not been aware of its importance. But, when I mustered the courage to bring it up, a whole array of experiences and emotions was revealed and became very significant to the success of this treatment.

B.2. Taking immigration into account during assessment process

Respondents mentioned the theoretical knowledge they acquired about the process of migration that guided their assessment of their clients:

(OB) I try to understand in what developmental stage they experienced migration, what are the unresolved remnants of this experience, what developed into a trauma, and in what way the immigration experience is reflected in the therapeutic relationships.

(IE) I am working with foster families and many of the children we send to foster care are immigrants. The course made me aware of the effect of immigration on the reality of life of families and how difficult it may be for immigrant families to understand their situation and cope with it. In staff meetings, in the reports that I write and in my direct encounters with clients, I now try to underscore issues related to migration as an inseparable part of the coping of the child and the family.

(TB) The ability I acquired in the course to see the connections between immigration processes and my clients' health helps me to gain the cooperation of clients and staff… I often share my understanding with our inter-disciplinary team in order to help them connect to the world of their immigrant clients.

Again, most impressive is the testimony of respondents who have themselves experienced immigration as illustrated in the following quote:

(MB) I must admit that although I immigrated at the age of 14, the course opened my eyes to the fact that the experience of immigration is a crucial aspect of my clients' lives.

B.3. Empathy

The above illustrations imply that the respondents gained more empathy in relationship to their immigrant clients. Some respondents mentioned this outcome overtly:

(SN) I have now a more sensitive view of my clients' complex reality.

(NY) When I put on my "new glasses" that I gained in the course, I can see my clients in a more sensitive way.

(TB) The comprehensive understanding of immigration and the psychological processes that accompany it made me able to create deeper and more containing relationships with my clients.

B.4. Recognizing and respecting cultural diversity

The extension of empathy seems to be the respondents'

greater awareness and tolerance of the "otherness" of their immigrant clients. Although mentioned only by few as a purely cognitive outcome, cultural sensitivity and respect for their clients' cultural background permeated many accounts of professional practice:

> (KZ) In this course I acquired tools that will help me to calibrate my therapeutic sensitivity towards immigrant clients, to understand and respect the norms they brought with them from their homeland.
>
> (OA) Recently, I worked with an immigrant family where the mother was very dominant and the father rather passive. This mother was also very worried about her adolescent daughter, although the situation of this girl in comparison to her native-born peers was really good. The mother was saying the "there" things were different than "here" and there were many clashes in communication between her and her "Israelized" daughter. I was so happy that I took the course and all this was clear to me.

Several respondents who expressed similar ideas via self-criticism:

> (NM) I grew to understand that we, social workers, are often patronizing in our interventions with immigrants and perpetuate the stresses that immigrants experience. When, without understanding the immigrants' world, we demand that they adjust to the society we live in and pressure them to abandon their homeland culture, we may be perpetuating their distress.

One of the respondents describes in detail the change that she experienced in her practice following the course:

> (MS) Before I took the course I was aware of the cultural diversity of my clients and of their different behavioral patterns and belief… However, this was merely "information" and once I entered the clinic, I chose to put this information aside. Instead I used to cling to familiar patterns, theories and therapeutic tools, which mostly apply to western cultures without ever testing their applicability to my clients' cultural background. Now, I am more aware of the link between my clients' cultural background and my ability to provide them with an appropriate service, with empathy, with a non-judgmental and non-prejudiced attitude… this strengthens my empathy and the therapeutic relationship. This awareness now puts me in the position of constant exploration of my own cultural patterns, norms and values.

CONCLUSIONS

Although it has been recognized that cultural competence is an essential component of training mental health professionals, there is surprisingly little research evidence that such training is effective (22). This study, which evaluated the outcomes of cultural-competence training, contributes to the limited body of research in this area. The findings consistently indicate that the training course had meaningful outcomes. On the cognitive level, students acquired insight into the centrality of immigration in the lives of individuals and families and the long-term ramifications of migration. They also gained understanding as to the psychological processes typical to the transition from one country, or culture to another. Parallel to getting familiar with universal processes in migration, students learned to appreciate the remarkably unique nature of the migration experience. This cognitive enrichment appeared to have influenced the students' practice with clients from diverse cultural backgrounds. They became more attentive to the experience of migration in their clients' lives, and addressed it in their communication with clients, in assessment of clients as well as with their colleagues. They reported that they became more empathic to their clients' experiences and difficulties and more tolerant and respectful of the cultural diversity among their clients.

The present study has several limitations. The qualitative methodology with a relatively small number of respondents, obviously limits the power of generalization of the results, as does the short-term of the evaluation that cannot reveal the long-term effects of the training. The fact that the evaluation is based on the subjective accounts by the trainees themselves is also a limitation. Similar limitations applies to most research on cultural competence, qualitative as well as quantitative, as most instruments in this field are self-report measures (25). The fact that the data were analyzed by one person is another limitation as no inter-rater reliability check was feasible. A quantitative research methodology, and especially with a control group design, would provide more robust data on the effects on practice following cultural training.

The training model and the evaluation were presented here with the hope to demonstrate the potential contribution of cultural-competence training to improving clinical practice and services for a diverse client population.

References

1. Chow W, Sadavoy J, Wong J. Working with cultural diverse persons involved in law and mental health - cultural competency training manual. Eur Psychiatry 2011;26:450-460.
2. Mezzich J, Kirmayer LJ, Kleinman A, Fabrega H, Parron D, Good B, Lin KM, Manson S. The place of culture in DSM-IV. J Nerv Ment Dis 1999;187:457-464.
3. Mezzich J, Giovani C, Fabrega H, Kirmayer L. Cultural formulation guidelines. Transcult Psychiatry 2009; 46:383-405.
4. Kirmayer LJ, Groleau D, Guzder J, Blake C, Jarvis E. Cultural consultation: A model of mental health service for multicultural societies. Can J Psychiatry 2003;48:145-153.
5. Shea M, Yang LH, Leong F. Loss, psychosis, and chronic suicidality in a Korean American immigrant man: Integration of cultural formulation model and multicultural case conceptualization. Asian Am J Psychol 2010;1: 212-223.
6. Borra R. Working with the cultural formulation in therapy. Eur Psychiatry 2008; 23: 43-48. .
7. American Psychological Association. Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. Am Psychol 2003; 58:377–402.
8. National Association of Social Workers (NASW). Cultural competence in the social work profession. In Social work speaks: NASW policy statement. Washington, DC: NASW Press, 2000: pp. 59–62.
9. National Association of Social Workers. Indicators for the achievement of the NASW standards for cultural competence in social work practice. Washington, DC: National Association of Social Workers, 2007.
10. Council on Social Work Education (CSWE). Educational policy and accreditation standards. Alexandria, VA, 2004.
11. Bennegadi R. Cultural competence and training in mental health practice in Europe: Strategies to implement competence and empower practicioner. International Organization of Migration: Background paper, 2009. Retrieved December 11, 2011 from www.immigrant-health-europe.org
12. Sue S, Zane N, Nagayama-Hall G, Berger LK. The case for cultural competency in psychotherapeutic interventions. Ann Rev Psychol 2009; 60: 525–548.
13. Lee MY, Greene GJ. A teaching framework for transformative multicultural social work. J Ethnic Cult Divers Soc Work 2003; 12:1-28.
14. Lu YE, Lum D, Chen S. Cultural competency and achieving styles in clinical social work: A conceptual and empirical exploration. J Ethnic Cult Divers Soc Work 2001; 9:1-32.
15. Dyche L, Zayas LH. Cross cultural empathy and training the contemporary psychotherapist. Clin Soc Work J 2001; 29: 245-258.
16. Harris TL, McQuery J, Raab B, Elmore S. Multicultural psychiatric education: Using the DSM-IV-TR Outline for cultural formulation to improve resident cultural competence. Acad Psychiatr 2008; 32:306-312.
17. Weaver HN. Teaching cultural competence: Application of experiential learning techniques. J Teach Soc Work 1998;17: 65–79.
18. Arbour MP, Bain B, Rubio R. An evaluation study of diversity training for field instructors: A collaborative approach to enhancing cultural competence. J Soc Work Educ 2004; 40:27-38.
19. Kerl SB. Using narrative approaches to teach multicultural counseling. J Multicult Couns D 2002; 30:135–143.
20. McCreary ML, Walker TD. Teaching multicultural counseling pre-practicum. Teach Psychol 2001;28:195–198.
21. Lough BJ. The principles of effective practice in international social work field placement. J Soc Work Educ 2009;45:467-480.
22. Bhui K, Warfa N, Edonya P, McKenzie K, Bhugra D. Cultural competence in mental health care: A review of model evaluations. BMC Health Serv Res 2007; 7:15-25
23. Teasley ML. Perceived levels of cultural competence through social work education and professional development for urban school social workers. J Soc Work Educ 2005; 41:85-100.
24. Colvin-Burque A, Zugazaga CB, Davis-Maye D. Can cultural competence be taught? Evaluating the impact of the SOAP model. J Soc Work Educ 2007;43:233-244.
25. Krentzman AR, Townsend AL. Review of multidisciplinary measures of cultural competence for use in social work education. J Soc Work Educ 2008;44;7-32.
26. Ministry of Health. Retrieved October 16, 2011, from http://www.health.gov.il/download/forms/a3876_mk07_11.pdf
27. Al-Krenawi A, Graham J. Culturally sensitive social work practice with Arab clients in mental health settings. Health Soc Work 2000; 25:9-22.
28. Al-Krenawi A, Graham J. The cultural mediator: Bridging the gap between a non-western community and professional social work practice. Brit J Soc Work 2001;31:665-685.
29. Arkin N. Culturally sensitive student supervision: Difficulties and challenges. Clinical Supervisor 1999; 18:1-16.
30. Arkin N, Freund A, Saltman I. A group supervision model for broadening multiple-method skills of social work students. Soc Work Educ 1999;18:49-58.
31. Ben-David A. Teaching awareness of cultural pluralism: The Israeli experience. Soc Work Educ 1998;17:101-110.
32. Ben-David A, Amit D. Do we have to teach them to be culturally sensitive? Int Soc Work 1999;42:347-358
33. Bilu Y, Witztum E. Working with Jewish ultra-orthodox patients: Guidelines for a culturally sensitive therapy. Cult Med Psychiat 1993;17:197-233.
34. Dwairy M. Toward psycho-cultural approach in Middle Eastern societies. Clin Psychol Rev 1999; 8:909-915.
35. Grisaru N, Budowski D, Witztum E. Possession by the "Zar" among Ethiopian immigrants to Israel: Psychopathology or culture-bound syndrome? Psychopathology 1997;30:223-233.
36. Grisaru N, Irwin M, Kaplan Z. Acute psychotic episodes as a reaction to severe trauma in a population of Ethiopian immigrants to Israel. Stress Health 2003;19:241-247.
37. Jaffe ED. Ethnic and minority groups in Israel: Challenges for social work theory, values, and practice. In: Weiner E, editor. The handbook of interethnic coexistence. London: The Abraham Foundation, 1998: pp. 585-599.
38. Lavee Y. Family therapy in a multicultural society: The case of Israel. In: Kit S, editor. Global perspectives in family therapy: Development, practice, and trends. New York, N.Y.: Brunner-Routledge, 2003: pp. 175-194.
39. Roer-Strier D. Reducing risk for children in changing cultural contexts: Recommendations for intervention and training. Child Abuse Neglect 2001; 25: 231-248.
40. Youngmann R, Zilber N, Workneh F., Gill R. Adapting the SRQ for Ethiopian populations: A culturally-sensitive psychiatric screening instrument. Transcult Psychiatry 2008;45:566-589.
41. Mirsky J. The use of narrative analysis and psychoanalytic exploration of group processes in multicultural training. J Appl Psychoanal Stud 2008;5:2-15.
42. Peterson JA, Van Meir E. Using patient narratives to teach psychopathology. J Marital Fam Ther 1996; 22:59–68.
43. Lijtmaer R. Strategies for coping with resistances in teaching multicultural courses. Paper presented at the 48th American Academy of Psychoanalysis and Dynamic Psychiatry Conference: New York City, April 2004.
44. Glanz L. Expatriate stories: A vehicle of professional development abroad? J Manage Psychol 2003;18:259–274.
45. Lieblich A. The holistic-content perspective. In: Lieblich A, Tuval-Mashiach R, Zilber T, editors. Narrative research: Reading analysis and interpretation. Thousand Oaks, Cal.: Sage, 1998: pp. 62-87.