Beyond Multicultural Competency: Pluralistic Multicultural Orientation Treatment (PMCOT)

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The present conceptual paper offers a model of multicultural treatment that seeks to learn from the client their important cultural identities, values and beliefs. Pluralistic Multicultural Orientation Treatment (PMCOT) extends the multicultural competency framework by integrating four independent but interconnected interventions to create a conceptual model. The multicultural perspective has been discussed within the literature for many decades; however, evidence is mixed as to its overall effectiveness. This conceptual paper reviews effective components of multicultural practice and effective methods for working with diversity in general and assimilates them into this conceptual model. Multicultural orientation, illness myth, pluralistic therapy and feedback informed treatment provide the key processes of PMCOT and its commitment to learn from clients, not about clients, their important cultural identities as they present in the therapy relationship. A discussion provides both strengths and limitations to this model and explores areas for possible further research.

Keywords: *Multicultural, competency, orientation, pluralistic, PMCOT*

Introduction

Research within counselling and psychotherapy is generally conducted within the Western world. Sue et al. (1992) suggest that therapy is, therefore, more suitable to this dominant culture and may not be congruent with other ethnic or racial groups, beliefs or values. At the same time, other researchers such as Frank and Frank (1993), and Wampold (2007), argue that counselling and psychotherapy are culturally encapsulated healing processes specific to particular cultural contexts.

Consequently, and supported by an ever-growing body of evidence (Davies et al., 2018; Owen et al., 2014; Owen et al., 2016; Wampold, 2015; Benish et al., 2011), addressing cultural experiences in therapy can help improve psychotherapeutic outcomes. While the broader field of psychology and the therapy field specifically have been attempting to address these gaps within the research, there is still a relative dearth of evidence as to how using a cultural competency framework impacts client outcomes and treatment outcome has shown heterogeneity in effect sizes (Huey et al., 2014; Tao et al., 2015). Thus, the present conceptual paper seeks to provide a model based on current evidence of what works in this area. Drawing on four individual but interconnected concepts, two of which are multicultural specific, namely, multicultural orientation and illness myth. In addition to two transtheoretical interventions, pluralistic counselling and feedback informed treatment, the author presents Pluralistic Multicultural Orientation Treatment (PMCOT).

PMCOT is presented here as building on the multicultural competency model through integration of independent and interconnected, and overlapping interventions from the extant literature. I present the conceptual model in a linear format illustrating how it can be used during the initial assessment, throughout the therapy process, and in monitoring the process of therapy by paying attention to the therapeutic alliance in a multicultural manner. Importantly, and at the heart of this conceptual model, is the idea that each of the four components of PMCOT is used to learn from our clients their important cultural values, beliefs and identities, and how these can inform therapeutic responsiveness from practitioners. While the four components are presented as a linear concept for ease of understanding their application, there is a great deal of overlap in their use during therapy.

Multicultural approach

Concerns have consistently been noted within the extant literature regarding the extent to which diversity has been included in research trials of evidence-based therapies

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and the extent to which these therapies are actually effective for those from diverse ethnic and racial population (Huey and Polo, 2008; Huey et al., 2014; Miranda et al., 2005; Sue et al., 2009). Disparities in mental healthcare treatment have been consistently identified within racial and ethnic minority groups, and studies have documented that many practitioners have better outcomes with White clients (Drinane et al., 2016; Hayes et al., 2015; Imel et al., 2011). This, of course, led to calls to research and make treatment more applicable and effective to this population.

However, although researchers have attempted to respond to these issues, overall, the evidence has been mixed as to the effectiveness. Indeed, some research studies have demonstrated that cultural tailoring can sometimes diminish the impact of general practice (Huey et al., 2014). At the same time, the multicultural and diversity literature has noted different methods of responding to these issues. While the multicultural competency approach has seemed to garner the most attention, there are questions concerning its applicability and effectiveness in general (Huey et al., 2014).

According to Hook et al. (2016), there have been high rates of racial-ethnic microaggressions in therapy, with as many as 53% to 81% of clients who have reported experiencing an experience of at least one microaggression. Clients who perceive racial-ethnic microaggressions from therapists have reported lower therapeutic alliances and diminished therapy outcomes (Owen et al., 2018).

In addition to this, differentiated models calling for different ways of addressing diversity have been added to the literature; this could be one of the issues impacting on establishing overall efficacy. Adaptations to treatment models, attitudes and processes have all been identified as effective components of multicultural treatment. However, limitations have been noted for each of these areas. Again, definitions for multicultural responsiveness have been defined differently, further adding burdens to addressing research questions. However, meta-analysis does provide some strong evidence overall, and it is this evidence that informs the present conceptual model, PMCOT.

Prominent multicultural studies

Smith et al. (2010), in a meta-analysis of 65 quasi/experimental studies, found that culturally adopted treatments had a medium effect size of (d=0.46), with treatments adopting metaphors/symbols that match the clients cultural worldview and treatments to specific ethnocultural identities being more effective. However, for the author, this may only be a fruitful approach for those working with specific demographics. Practitioners would have to learn an insurmountable amount of treatment approaches with specificity to work with the variety of multicultural identities who attend routine practices. At the same time, many of the studies in this meta-analysis did not test direct comparison; thus, caveats apply.

Similarly, Griner and Smith's (2006) meta-analysis found that treatment adapted to specific cultural identities was as much as four times as effective (d=0.45), and matching clients to therapists who speak their own language were up to twice as effective.

In their meta-analysis, Benish et al. (2011) found that culturally adapted psychotherapy for race/ethnicity is more effective than un-adapted (d=0.32) compared against bona fide therapies. Adaptation of the illness myth was the sole moderator of superior outcomes via culturally adapted psychotherapy. The smaller effect size, when analysed against the above Smith study, may be accounted for by the direct comparison studies and provides us with more reliable findings.

Huey et al. (2014, p.1), in their Annual Review of Clinical Psychology, posit that "support for cultural competence as a useful supplement to standard treatment remains equivocal at best". However, they do note the findings from the above Benish et al. (2011) study and the adaptation of the illness myth and its link to common relational factors, and note some of the findings from the Smith et al. (2010) meta-analysis, specifically, matching worldview, metaphors and symbols. The illness myth adaptation would seem to be congruent with the general psychotherapy outcome variance literature, that suggests building expectancy, hope and providing a rationale for treatment outcome/ credibility produces superior outcomes (Duncan et al., 2011; Constinano et al., 2018; Constinano et al., 2018; Frank and Frank, 1969; Wampold, 2015; Wampold and Imel, 2015). For these empirical reasons, illness myth (discussed later) is incorporated into the present conceptual model.

Tao et al. (2015) meta-analysis of multicultural competency examined MC and its correlation with several processes and clinical outcomes. Specifically, MC was correlated with process measures (r =.075) and clinical outcomes (r =0.29). In addition, there was a strong correlation between general counselling competencies and satisfaction with therapy.

The analysis in this study suggests that client ratings of practitioners' MC account for approximately 37% of the variance in the therapeutic alliance, 52% of the variance in client satisfaction, 38% of the variance in general competency, and 34% of the variance in session depth. Thus, Tao et al. (2015, p.344) suggest that 'therapist MC should be considered an important empirically supported therapeutic relational factor', with a variance of approximately 8.4% on outcomes. Based on this evidence, the PMCOT model incorporates informed feedback treatment (alliance and outcome measures) and the pluralistic approach with a focus on preference accommodation (satisfaction) into the model (discussed later). In addition, both can be considered trans-theoretical general competencies.

The most recent secondary analysis within the multicultural domain is a narrative review by (Davies et al., 2018.). This review examined the evidence for the multicultural orientation (MCO) (Owens et al., 2015), with individual studies within the narrative review providing evidence for correlations between one of the three aspects of MCO (discussed later) and outcomes. Due to the strong emerging evidence for the multicultural orientation approach and it's process/attitude orientation, it is incorporated into the present conceptual model. The MCO provides a lens in which the practitioner considers how their own cultural conditioning interacts with the clients and the healing potential and barriers that may come from these interactions; in addition to providing a general direction on how to go about broaching cultural markers as they present in the session, that is, the process (Davies et al., 2018; Owen et al., 2014).

Multicultural competencies

The multicultural competency movement can be considered the fourth force in psychotherapy, following on from the psychodynamic, behavioural and humanistic traditions

(Pederson, 2002). The competency movement has gained increasing attention since the 1980s across settings such as psychiatry, psychology, therapy and social work. Multicultural Competency (MCC) proposes that it is possible to learn to work with diverse client populations across cultures, identities and treatment paradigms by adopting treatment to specific cultural identities.

The MCC approach stipulates three broad ideas; (1) that there are a set of competencies that can impact client outcomes and can be acquired by therapists through a standardised training regime. (2) competency in these skills can be assessed and identified in the therapist; (3) the competencies are a standard characteristic across client populations.

However, there is little support for the position that multicultural competencies are a stable characteristic of the practitioner, as studies have not illustrated adequate convergence across ratings of the same practitioner (Owen et al., 2011), or that competencies are strongly linked to outcomes. This is not surprising when we contextualise it within the general outcome research in counselling. That is, the correlation between therapist competency and client outcomes is weak, with less than 1% of the variance in therapy outcomes accounted for by competency (Wampold, 2015; Wampold and Imel, 2017; Webb et al., 2010).

Thus, employing another competency framework for cultural counselling may not be the most effective method to improve client outcomes. Instead, a 'way of being ' (Owen et al., 2016) in sessions is proposed, which would be more aligned to the factors set out in evidence-based relationships (Norcross & Lambert 2001; Norcross & Wampold, 2018; Norcross & Wampold, 2019) and outlined within my rationale for the PMCOT model.

The model of cultural competency most often cited and recognised is the person-based model (Chu et al., 2016). The person-based model proposes three components, namely, self-awareness of one's own cultural background and how this impacts practice; knowledge about the worldview and culture of those from diverse cultural backgrounds; and learning skills in culturally appropriate treatment interventions (Sue et al., 1982; 1992; 2013). Often referred to as the tripartite model (Chu et al., 2016), of multicultural knowledge, skills and attitude, or KSA (Watkins et al., 2019). Perhaps reflecting the wider discourse in psychotherapy, Watkins et al. (2019) argue that the knowledge and skills components have received more attention, with the attitudinal aspect lagging. However, Ratts and Pederson (2014) and Ratts et al. (2016) would suggest that it is the attitude component that provides the KSA with its foundation and successful implementation. As Gonsalvez and Crowe (2014, p.22) argue, "the 'big' competencies with deep impact are attitude-value attributes."

Pluralism

The pluralistic approach is a collaborative philosophy and practice rooted in humanistic and person-centred values. Its fundamental proposition is that each client is unique, and therefore may need different things from therapy (Cooper & McLeod, 2000). This idea and flexibility converge nicely with the illness myth, which itself can be considered cultural pluralism. That is, clients may have different culturally specific ideas of how the treatment should work and what type of approaches and methods will be helpful. One way the pluralistic approach can help with mitigating some of these issues is through preference accommodation. Swift et al. (2018) demonstrate in their meta-analysis that preference accommodation is associated with superior client outcomes and reduced early attrition, both of which have been shown to disproportionately impact clients of diversity. Cooper and Norcross (2016) provide the Cooper Norcross Inventory of Preference to help incorporate important issues into treatment, such as style of therapy, format, and focus. There is also a question relating to client preference towards their therapist across demographics of diversity. While not a cultural specific inventory, it does provide a good starting point to begin incorporating important client preferences in general, which can be explored under a cultural lens also

The cultural implications of research, treatment and our understanding of therapy also need to be carefully considered, lest they are not congruent with the clients' experience of their emotional problems. While this is important for all people, it comes into a sharper focus when we consider diversity. For example, the Western worlds diagnostic system of pathologising, is certainly not consistent with all cultures. Our research and training have taught us to re-cast other people's experiences in terms of our own culturally situated symbolic system. Thus, the pluralistic concept has been incorporated into this conceptual model as a starting point for addressing cultural preferences. It may be used during the assessment phase or before the first therapy session occurs, thus, orientating practitioners to important cultural markers that are identified and can be followed up with other multicultural interventions, for example, the idea of using the illness myth.

Illness Myth

Articulated previously, one of the methods of successful culturally informed psychotherapy was documented in the Benish et al. (2011) meta-analysis through the illness myth. As far back as 1962, Wrenn described psychotherapy as culturally encapsulated, calling for more cultural diversity in the delivery of treatment. Frank and Frank (1963) and Wampold (2007) suggest that an important aspect of universal healing is the cultural explanation and a set of healing rituals provided to the clients, which are embedded within a cultural context. "What is important to the sufferer is not the scientific validity or falsifiability of the illness explanation but rather the congruence of the explanation with the client's cultural beliefs about the illness" (Benish et al., 2011, p.281).

The adaptation of illness myth would seem to be especially important in providing a rationale that is consistent with the clients cultural understanding, beliefs about symptoms, aetiology, how the issues will evolve, and opinions on acceptable treatment approaches. Considering the impact that incorporating the illness myth has on outcomes (Benish et al., 2011) and its attitudinal/process orientation, we find that it is a good fit and evidence base for PMCOT. The illness myth can be used throughout therapy; however, we see the benefit in its use during the assessment phase, and it can be used in conjunction with preference accommodation, especially when multicultural needs have been initially identified through administering the Cooper-Norcross Inventory of Preferences. As such, it is a starting point where the practitioner can learn from the client their important cultural identities, how they view their presenting issues, and what, if any, ideas they have regarding treatment within a cultural context. At the same time, we need multicultural practices that can be used in the moment. Owen et al. (2018) discuss multicultural orientation as a way to achieve this.

Multicultural orientation

For Watkins et al. (2019), the Multicultural Orientation (MCO) can be viewed "as a process-oriented, attitudes-additive perspective to the MCC KSA framework". MCO is used to operationalise the process-oriented perspective and as a complement to the attitudes component of the KSA framework; and the multicultural competency approach in general (Davies et al., 2018). The MCO approach is made up of three interconnected and interdependent ideas; cultural humility, cultural opportunity and cultural comfort. "The cultural worldviews, values, and beliefs of the client and the therapist interact and influence one another to co-create a relational experience that is in the spirit of healing." (Davis et al., 2018, p. 90).

Culturally humble therapists seek out markers for cultural opportunities to enquire into clients identities that arise in session. These culturally humble therapists seek to find cultural comfort in these interactions while engaging differential client cultural identities. While cultural humility seems to be the foundation of this orientation, Watkins et al. (2019) suggest that on its own, it may not be enough to improve outcomes.

Cultural humility can be considered a virtuous component of the MCO approach. Increasingly, those across disciplines within the mental health domains have come to understand humility as an alternative and/or complementary language to the competency approach (Foronda et al., 2016; Davies et al., 2018). Humility is conceptualised as consisting of both intrapersonal and interpersonal components. That is, a level of self-awareness regarding the view a practitioner holds of themselves and their limitations; and the extent to which one is other orientated rather than being consumed with Self and their superiority over others.

We can therefore extrapolate that cultural humility as a subdomain of humility is the extent to which a practitioner can hold an interpersonal position with a client that is curious about their cultural identity; or as Hook et al. (2013, p.354) articulate, "the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client."

Importantly, cultural humility goes beyond the traditional position of 'not knowing' adopted by practitioners and actively seeks to learn from clients their cultural identities. If cultural humility is the motivational factor for practitioners who want to find out about others important identities, then cultural opportunity and cultural comfort can be considered the in-session behaviours when these markers are identified and need to be broached. Said another way, through cultural humility, practitioners identify important cultural markers as they present in the session and broach the subject using cultural opportunities and cultural comfort.

Owen et al. (2016) describe cultural opportunities as those points in a session where important cultural beliefs, values and identities present and can be explored by both practitioner and client. At the same time, cultural opportunities are always present, and therapists should feel that they can broach these issues if they feel that there will be therapeutic value in situations where cultural opportunities may not be manifest. Davies et al. (2018) suggest doing this gently and authentically and without big transitions or forcing the issue. Hence, practitioners who practice cultural humility and opportunity will have a certain level of ease with engaging in these practices, that is, cultural comfort.

Cultural comfort explains the level of ease that practitioners experience before, during and after conversations with clients about their cultural identities (Owen et al., 2017). While cultural comfort would be needed to navigate the complex interpersonal dynamics that occur in session, cultural discomfort may be a good indication that something has been triggered and needs attending to; as such, Davies et al. (2018) use the language of cultural transference and counter-transference. Viewed under this lens, feelings of cultural discomfort may precede cultural humility and would seem important for practitioners to identify as they may impede therapeutic progress.

The current evidence for MCO in therapy is emerging as strong across a number of studies (Davies et al., 2018; Hook et al., 2013; 2016; Owen et al., 2014; 2015; 2016). Owen et al. (2018) found that clients who experienced microaggressions from their therapists experience worse therapeutic alliances and worse therapy outcomes. At the same time, Owen et al. (2018) found that therapists ability to identify 1 of 3 microaggressions in simulated sessions was 38% to 52%. Hook et al. (2016) demonstrated that for clients who experienced microaggressions, cultural humility predicted the number and impact of this aggression after controlling for general multicultural competencies, indicating the added value of humility.

In a retrospective study, Owen et al. (2016) examined therapist cultural humility and missed opportunities. Findings suggest that clients who rated their therapist as culturally humble had better therapy outcomes, while those who rated their therapist as having missed opportunities to discuss their cultural identity (cultural opportunity) reported worse outcomes. Again, Owen et al. (2014), in a study focused on religious, cultural identities, reported that therapists who were more culturally humble with religious clients had better outcomes.

It's not surprising that multicultural orientations seem to be mediated by the therapeutic alliance. Hook et al. (2013, study 1) found that cultural humility was correlated with the alliance. In a second study, Hook et al. (2013, study 2) demonstrated that cultural humility correlated with the alliance and client outcomes. In a third study, Hook et al. (2013, study 3) found that cultural humility mediates the alliance and client outcomes. Taken together, these seven empirical studies demonstrated positive client outcomes, and thus, the MCO is incorporated into the present conceptual model. However, as illustrated previously, it is not just the MCO that has demonstrated effectiveness; other cultural processes are also impactful and need consideration.

Feedback Informed Treatment (FIT)

One of the most cited rationales for clinicians incorporating multicultural competencies into therapy is how poorly clinicians attend to ethnic and other minorities (Huey et al., 2014) and the disparities within mental health outcomes for these populations. However, individual clinician experiences and opinion may not be congruent with the literature. For example, several studies during the last 30 years (e.g. Allison et al., 1996; Hansen et al., 2006; Holcomb-McCoy & Myers 1999; Lopez & Hernandez, 1986; Maxie et al., 2006) of predominantly White therapists illustrates that between 72-91% of clinicians perceive themselves as practising multicultural competencies to some extent. For the author, it is difficult to reconcile these statistics. While Benish (2010) suggests that this may be reflective of a certain level of cultural competency as a norm, another way to view these statistics could be through the lens of cognitive bias

on the part of practitioners.

The less knowledge, expertise and self-awareness one has about a field of practice; the more likely one is to overestimate their degree of knowledge in that area (Kruger & Dunning, 1999). So, having less expertise working with an area of diversity might make it harder for one to see one's limitations in that area. This bias, combined with self-enhancement dispositions, may make it difficult for practitioners to perceive and take responsibility for their limitations (Davis et al., 2018). Indeed, Fuertes et al. (2006) and Dillion et al. (2016) found that counsellor's self-assessment of their multicultural competencies was found to exceed that of their client's assessment. This may not be overly surprising considering the previously cited Owen (2018) study on therapists ability to spot microaggressions as they happen in session.

At the same time, the general psychotherapy literature informs us that clinicians tend to overestimate their rates of client improvement and underestimate their rates of client deterioration (Chow et al., 2014; Walfish et al., 2012). Thus, in the studies cited above, clinicians may be overestimating their abilities and or use of cultural competencies. One method to help practitioners improve these issues is by tracking their progress, outcome and process of care with standardised measures. Coupled with the previous research attesting to the power of the alliance in multicultural therapy, feedback approaches would seem to be indicated as helpful tools.

FIT is an evidence-based trans-theoretical approach for improving the outcome and process of behavioural healthcare. It involves using two ultra-brief measures at every session to solicit feedback from clients on the therapeutic alliance and outcome of care and using the information provided to adapt the therapists approach in real-time to meet these needs. FIT uses the Outcome Rating Scale (ORS) to solicit feedback on how the client is responding to treatment, that is, the benefit they are getting from therapy. The Session Rating Scale (SRS) is used to assess the therapeutic alliance.

Both measures are reliable and valid tools, and meta-analysis has demonstrated that their use to improve therapy outcomes by helping to identify those not benefiting from care; at risk of early termination, and those actively deteriorating while in care (Brattland et al., 2018; Lambert et al., 2018); all of which make up a significant percentage of clients in routine practice.

Specifically, the SRS can be used to keep track of the therapeutic alliance in general, but also within a culturally informed manner. As the measure tracks the extent to which clients are satisfied with the bond between themselves and the practitioners, the goals and topics discussed, and the methods and approach used. In doing so, practitioners may also garner a clearer picture of their multicultural abilities and align their process orientation more towards the individual diversity, and intersectionality's that their clients present with, reducing possible self-effectiveness bias. At the same time, previously cited studies have suggested that therapists may be unaware of microaggressions that occur in session; thus, tracking the alliance with a structured measure at the end of each session may be one way to identify and attend to cultural ruptures in real-time.

Considering that all of the empirical studies discussed previously indicated that multicultural outcomes were mediated through the alliance, it makes sense that we explicitly attend to this when working with diversity. Indeed, in their meta-analysis, Tao et al. (2015) suggest that clients perceptions of their therapist's multicultural competency account for 37% of the variability in the therapeutic alliance. While FIT has a specific meaning regarding feedback, all the concepts discussed previously seek feedback from clients in some manner, and it is this attitude of learning from the client that is at the heart of PMCOT.

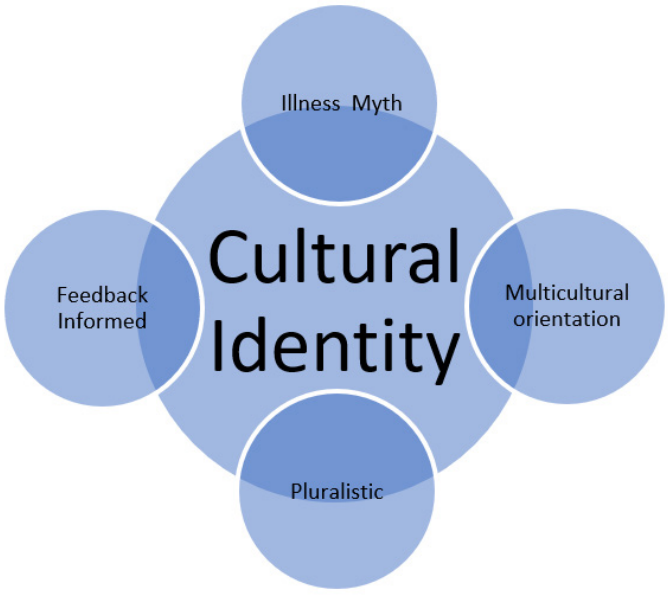
Implications for practitioners

Learning about others culture can be quite difficult, not least because what we learn may not be representative of the wider population, re-stereotyping may occur, and outliers are always present. While adapting to specific ethnocultural populations is one way of providing multicultural support, it is beyond the scope of any practitioner to learn about all cultures and their intersectionality's. It is just not feasible to learn about others important beliefs, values and cultural identities from a book chapter.

Therefore, an approach that can be utilised with differential cultures and their intersectionality would certainly be more feasible for the average practitioner. Huey et al. (2014), in their *Annual Review of Clinical Psychology*, note that approaches to multicultural therapy that has high training needs, complex protocols and substantial costs that further narrow their applicability to specific demographics are unlikely to be adapted and maintained by clinicians.

In response to this, PMCOT (Figure. 1) aims to offer a brief, uncomplicated multicultural model that can be used with diverse, multicultural populations and intersectionality, and be assimilated into current practices with relative ease and without competency protocols which account for little in the way of variance in change generally.

Figure.1



Discussion

Since multicultural competency presented on the horizon over 50 years ago, the idea of multicultural practice has been embraced at different levels by different disciplines and practitioners. Yet, the research literature is often ambivalent on its conceptualisation and effectiveness as it relates to diversity and the outcomes associated with care. At the same time, multicultural competency has scant evidence to support its consistent effectiveness. Inconsistencies have been demonstrated in the literature, with different studies having different outcomes and

practitioners not being consistent with its use as rated by clients

The present paper contributes to the extant literature in several ways. Firstly, it responds to Huey et al. (2014) call for a multicultural approach that is not overly complicated with excessive training regimes, competency-based protocols, and financial burdens. Secondly, it adds to the current body of knowledge in the multicultural arena by moving beyond the multicultural competency approach, adding a phased approach that can be used to identify and learn about clients multicultural identities. At the same time, PMCOT distils concepts already within the literature that have meta-analysis support for their individual effectiveness in multicultural domains and related practices.

Thirdly, one of the strengths of PMCOT is that it incorporates the evidence of multicultural factors that have shown to be effective and offers a mechanism to track and monitor whether these interventions are being helpful in the naturalistic setting. In light of the PMCOT process orientation, these tracking systems may be especially important for outcomes and the author hypotheses that it could be these aspects that give PMCOT predictive validity over some of its individual components. Finally, the use of measures of the alliance and outcome of care can assist practitioners in maintaining focus with multicultural issues that are important to clients; to repair ruptures in the alliance that may be caused by microaggressions, lack of cultural humility, or missed cultural opportunities.

The limitations of the present paper are concerned with the lack of primary data to understand if PMCOT is actually effective in clinical practice. Given that it is based on the most recent research trials, we can be confident that some aspects of the model will likely provide for effective multicultural therapy. However, the extent to which this would be more or less effective is unknown in the absence of primary data. Thus, future research may wish to study PMCOT within a clinical environment with primary data. In order to establish relative efficacy, a RCT with established active controls would need to be considered. The MCO model or the illness myth method would both individually be considered active controls and would provide data regarding the extent to which PMCOT may add value beyond these individual components. Furthermore, a dismantling study that removes different components of PMCOT is another possible methodology that may be considered, or indeed a relative effectiveness study with the multicultural competency approach.

Conclusion

This conceptual paper sought to address the gaps in multicultural practice by providing a model of multicultural therapy that will add to the existing literature in a meaningful way. Thus, PMCOT is a process-based model drawing on research from a meta-analysis in the multicultural domain and meta-analysis in other components of therapy that have demonstrated effectiveness. PMCOT adds to the competency skills and knowledge-based components by addressing the attitude and processes needed by effective multicultural practitioners. In doing so, PMCOT has at its heart a commitment to learn from the client and not about the client. This is demonstrated by the PMCOT model having in each component a feedback mechanism that seeks to understand the client's experience of an important cultural issue, their impact on their experience in therapy, and the outcomes associated with quality care. Thus, practitioners may wish to consider this model as a valid addition to their multicultural practices.

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