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A systematic review of graduate training on cultural competence

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Abstract

A systematic review was conducted to investigate scholarship from the last ten years regarding graduate training for the provision of culturally competent mental health care to individuals who hold marginalized identities (e.g., those marginalized based on their race, ethnicity, gender, sexual orientation). This review furthered a conceptualization of cultural competence that views clients as individuals embedded within their own cultures and communities while also recognizing the interplay of systems of power and oppression within an individual's life that create unique lived experiences. This was accomplished by conducting a systematic literature review following PRISMA guidelines. Seven databases (i.e., PsycINFO [EBSCO], PubMed, Psychology and Behavioral Sciences Collection [EBSCO], Academic Search Complete [EBSCO], SocIndex [EBSCO], Science Direct, ProQuest) were searched using a priori-defined search strings that encompass graduate training, cultural competence, and the various mental health care fields. Recommendations for improving cultural competence conceptualizations, engendering innovative training interventions, and increasing rigorous evaluation tools are provided.

Introduction

Graduate programs, governing boards, higher education faculty, and clinical directors play a crucial role in setting the stage for a foundation of training that emphasizes diversity and multicultural awareness within the training and skills instilled in their students in mental health training programs. Effective anti-racist and social justice-oriented training prepares clinicians to work effectively with marginalized communities. A social justice orientation, for the purposes of this review, is an ideology that reflects the pursuit of social, economic, and political equality with a basis on acceptance and celebration of difference and diversity (Craig, 2002). This involves culturally competent care, which considers the systems of oppression individuals must navigate while actively working to dismantle these systems that harm the clients one works with (Chung & Bemak, 2011; Matthew & Adams, 2009).

Cultural competence (with a particular focus on understanding systems of power, privilege, and oppression) among mental health service providers holds promise for improving the quality of mental health care provided to individuals who hold marginalized identities (Ali & Sichel, 2014). Within the United States, oppressive structures of power perpetuate unequal distribution of resources across various societal institutions, marginalizing many groups that fall out of the privileged majority (e.g., White, heterosexual, cisgender, middle class; Moradi, 2017). Despite this harrowing context, many mental health care workers lack the proper training and understanding to acknowledge how systems of power and domination uniquely affect the developmental and mental health outcomes of marginalized individuals.

Since their inception, the mental health care fields (e.g., psychology, psychiatry, social work) have neglected to include a diverse set of voices within training, research, and practice (Hall, 2014), and the underrepresentation of marginalized groups in the field has contributed to treatment that often times fails to account for the unique lived experiences of marginalized community members (Koç & Kafa, 2019). However, over the past 40 years, incorporating culturally competent care into treatment services for marginalized individuals has become a growing area of focus within graduate training programs (Sue et al., 2009). Despite growing attention to this construct, cultural competence within mental health care training and practice lacks a standardized definition (Benuto et al., 2018), and definitions that are frequently endorsed do not always account for the structural forces that define the lived experiences of oppression and marginalization that individuals must contend with on a daily basis (Danso, 2018). The current systematic review is inclusive of studies published within the past ten years that have focused on training graduate students in the mental health field on cultural competence.

Historical context

Historically, the mental health care fields' relationship with marginalized groups (e.g., people of color, people with disabilities, LGBTQ individuals) has been stigmatizing and oppressive. Ideologies that have centered ideas of White supremacy, misogyny, homophobia, and ableism have dominated research and practice. The mental health care field, alongside countless other fields and disciplines, have failed to actively resist these oppressive philosophies and instead have allowed them to permeate and persist (Constantine, 2007; Tasca et al., 2012; Tievsky, 1988). Consequently, across a number of instances, diagnoses and treatment have been disenfranchising through the advancement of discriminatory theories (e.g., Morton's theory of craniometry, idea of "feeble-mindedness"; Allen, 1984; Radford, 1991). Moreover, research in the field of mental health has been grounded in ideas of homophobia, white supremacy, and misogyny (Hall, 2014). For centuries, social welfare programs (the precursors to the field of social work) were complicit in the identification and removal of individuals who exhibited any kind of "abnormal behavior," with a privileged minority arbitrarily deciding which groups to other and oppress (Mackelprang & Salsgiver, 1996). While stigmatization originally concentrated on individuals with cognitive and physical disabilities (e.g., Buck vs. Bell; Lombardo, 1985), the mental health care field's use of diagnoses to marginalize individuals broadened to include gender minorities, racial/ethnic minorities, and sexual minorities. For the purpose of this review, "minority" does not describe a quantitative state of being but rather is used to describe groups that have been excluded from mainstream social, economic, and educational life.

Multicultural education

In order to understand the importance of multicultural education within mental health care training, it is essential to first define "culture." Most definitions of culture consist of describing it as a set of discrete behavioral norms and thought processes shared by individuals within a definable population that are distinct from those shared within other groups (Lehman et al., 2004). More contemporary definitions conceptualize culture as a system, specifically an interconnected relationship between peoples, places, and practices, for the ultimate purpose of enacting, justifying or challenging power within a social context (Causadias, 2020). Causadias (2020) defines people in this cultural model as referring to population dynamics, cultural groups, and social relations; places refer to institutional influences, ecological dynamics, and cultures within various contexts; practices refer to community engagement and culture being enacted. All three of these cultural components exist in mutual relationship with one another in order for certain groups to obtain power, the ability to force others into compliance, force others to behave as desired, and the ability to control access to spaces (Causadias, 2020).

An individual's culture is affected by the social context in which they inhabit, with sociocultural factors arising from the interconnected nature between social issues and cultural phenomena (Yamada & Brekke, 2008). These factors include a variety of social issues associated with minority status (e.g., immigration stress, racial discrimination), which culminate in defining how individuals within marginalized populations experience culture and oppression within the Western context. Conceptualizing culture as a system designed

to enact power onto groups of individuals allows us to understand how different groups experience oppression within the U.S. context. Oppression, which operates as a cultural system, has negative effects on physical and psychological health outcomes and thus is pivotal to understanding how mental health is conceptualized for members of marginalized groups (Seaton et al., 2018).

Many concepts have arisen over the years that have attempted to capture the interplay between sociocultural experiences and individual mental health. Cultural sensitivity was posited as the awareness of cultural information and schemas that a client holds and incorporating this cultural information into one's own behavior and thought processes when interacting with clients (Kumpfer et al., 2002). Relatedly, the idea of cultural competence has been advanced to capture the awareness of culture and the application of this knowledge to diverse clients (Betancourt et al., 2003; Huey et al., 2014; Lakes et al., 2006; Whaley & Davis, 2007). Cultural humility, building off of both cultural competence and sensitivity, goes a step further by incorporating the importance of critical self-examination of one's own cultural awareness, openness to new cultural information, and emphasizing a lifelong motivation to learn from others (Hook et al., 2017; Mosher et al., 2017).

While many previous definitions have focused more broadly on an examination of difference and culture without an examination of structural and institutional forces, we aim to further the conceptualization of culture as a system in which individuals are both acted upon as well as agents themselves in relation to power structures. By viewing culture as a mutually interacting system designed to perpetuate various forms of subordination, we are able to integrate both cultural awareness and an examination of hegemonic power within the U.S. context that contributes to different lived experiences for marginalized populations (relative to privileged groups) that lead to negative physical and psychological outcomes (Causadias, 2020). This review, therefore, aims to highlight the importance of integrating a conceptualization of culture that goes beyond individual difference, but focuses on practitioners understanding that marginalized populations experience cultural systems that often can have deleterious effects on their development and everyday lives. Therefore, we will be using the definition espoused by the National Association of Social Workers (NASW) in 2015, which defines cultural competence as including: (1) the awareness of how diverse populations experience their uniqueness in a larger context; (2) an understanding of intersectionality that examines oppression, discrimination, and domination; and (3) a recognition of the individual's position of prerogative and entitlement in relation to the populations they serve and with a recognition of the need to exercise cultural humility (Lusk et al., 2017).

Marginalized individuals within the U.S. from different cultures and identity groups experience distinct social upbringings that collide with various oppressive forces, and these experiences shape behavior, cognition, and reaction patterns (Lehman et al., 2004). This can affect how one conceptualizes the formation and maintenance of mental disorders as well as an individual's willingness to receive psychotherapy, suggesting that failing to take into account systems of power and the resulting marginalized experiences of individuals may lead to poor treatment conceptualization and outcomes (Koç & Kafa, 2019). All individuals, regardless of their background, should be able to have access to responsive and effective treatment while having freedom from harm from incompetent providers.

Current models of multicultural training aim to move past conceptualizations that homogenize marginalized groups, though attempts to standardize treatment recommendations may reify stereotypes of marginalized groups and promote reductive stereotypes when teaching clinicians how to take into account the identities of marginalized individuals. Additionally, evaluation approaches to cultural competence training have been variable and inconsistent (Benuto et al., 2018; Curtis-Boles & Bourg, 2010; Merta et al., 1998; Roysicar et al., 2005; Stanhope et al., 2005). The diverse nature of current evaluation methods lacks standardization in both methodology and scope of what defines cultural competence and how to best measure it, complicating the ability of graduate programs to effectively determine if their training for students is effective in method and outcome.

Current study

Political landscapes defined by racist discourse that promote the establishment of oppressive policies have led to an increase in the visibility of state-sanctioned violence against various marginalized communities (Aymer, 2016; Grills et al., 2016). Oppression has become endemic to the U.S. context, and structures of power have allowed marginalizing policies and rhetoric to permeate the lived experiences of targeted groups (Anderson et al., 2022). This recent increase in salience of marginalization in the U.S. has led to increased stress and anxiety within marginalized groups, pushing the importance of cultural competency and multicultural education (Williams & Etkins, 2021). Relatedly, there has been an uptick in the development of cultural competence trainings that have been disseminated to graduate programs regarding best practices for instruction (Celinska & Swazo, 2021; Dameron et al., 2020; Ratts et al., 2016).

Culture, however, has been defined in a variety of ways, oftentimes failing to account for the sociohistorical context and power structures that marginalized individuals must contend with and often bring into the clinical setting. Educational systems often reproduce colonial power structures and fail to include the voices and experiences of marginalized individuals necessary to provide culturally competent clinical care (McLeod et al., 2020). Some argue that clinical care of marginalized groups should include more than just an understanding that they hold distinct marginalized identities (Hansen et al., 2018). Clinical care to marginalized groups could also center critical reflection on how individual psychopathology is engendered from interactions between biology, environment, and historically (and currently) marginalized realities; integrate this understanding into treatment provision; and consider opportunities to change structural realities to make society more equitable (Kirmayer et al., 2018). In order to map the evidence base and identify knowledge gaps and weaknesses within the current conceptualizations of cultural

competence, a systematic literature review was employed, as this methodology has the potential to inform evidence-based policies and practice within clinical care (Mallet, 2012). The current review aims to take inventory of recent training and intervention methods aimed at increasing cultural competence (specific to the treatment of individuals who hold marginalized identities) among those training to become mental health care providers. This review also aims to document advances in the conceptualization of cultural competence specific to service provision to marginalized individuals.

Methods

The systematic review method is a rigorous and powerful tool to summarize the evidence base and identify gaps within the literature. Systematic reviews, however, can often face the challenge of subjective screening and quality appraisal methods used to assess the relevance and inclusion of articles and studies within the scope of a review (Mallet et al., 2012). Therefore, our approach was to adopt strict inclusion and exclusion criteria to minimize the chances of bias influencing the selection of articles in the final analysis. Inclusion criteria included: (a) the article concerned graduate training or topics related to graduate training and cultural competence, such as multicultural competence, learning, and cultural sensitivity (b) the article used original quantitative or qualitative data, or presented theoretical frameworks related to the topic (c) the article, if it was an empirical study, included graduate students, such as masters students, doctoral students, or other post-baccalaureate programs (d) the topic of multicultural competence training concerned individuals who held historically marginalized identities (e.g., racial/ethnic minorities, sexual minorities, gender minorities, low-income individuals) (e) the article focused on fields that concerned mental health care (i.e., psychology, psychiatry, social work) and (f) the article had undergone a peer-review process and was published in an empirical journal. Given that marginalization and oppression manifest differently across diverse global contexts and that training models for graduate education in mental health professions vary meaningfully across countries, we only included studies in our review that were conducted in the United States. Exclusion criteria included: (a) the study was conducted outside of the U.S., (b) the article concerned cultural competence training in a field outside of the mental health care fields, (c) the study sample was not comprised of graduate students, (d) the article did not focus on cultural competence training and (e) the article did not promote an understanding of cultural competence that accounted for systems of power, oppression, and social hierarchy. The review was conducted following the PRISMA guidelines (see Figure 1).

Seven databases (i.e., PsycINFO [EBSCO], PubMed, Psychology and Behavioral Sciences Collection [EBSCO], Academic Search Complete [EBSCO], SocIndex [EBSCO], Science Direct, ProQuest) were searched using an a priori-defined search string: ("cultural competence" OR "cultural competency" OR "cultural awareness" OR "cultural sensitivity" OR "multicultural competence" OR "multicultural competency") AND (training OR education OR development

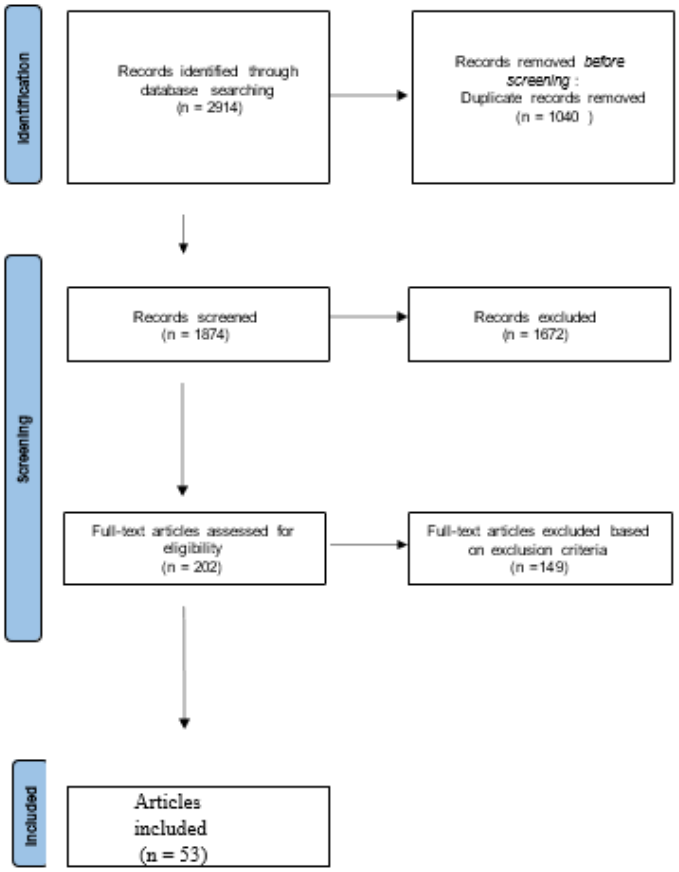

Figure 1. Prisma flow diagram.

OR learning) AND ("graduate students" OR "masters students" OR "doctoral students") AND ("mental health" OR "psychology" OR "social work" OR "psychiatry"). Previous reviews, reference lists, and additional searches were also utilized to identify potential articles. We restricted our search to articles published in or after 2010, as this was the year of the last comprehensive review of multicultural competence training in the field of mental health that we were able to find (i.e., Rogers & O'Bryon, 2014). The search strategy produced 2914 articles. After duplicates were removed using Microsoft Excel, there were 1874 remaining articles to be screened using the article title and abstract. Of the articles screened 202 articles were identified as potentially relevant based on inclusion criteria. Then, the full-text article was retrieved to determine whether all inclusion criteria were met, removing an additional 149 articles. The final sample consisted of 53 articles.

Results

53 articles were included in this review. 30 articles (54%) were conceptual in nature and concentrated on presenting recommendations for clinical practice with individuals who hold various marginalized identities; introducing innovative theoretical conceptualizations of multicultural competence training; and understanding how standards for multicultural competencies set by governing bodies can best be incorporated into training. Two articles (5%) were descriptive in nature, focused on disseminating data regarding perceptions of student competence and correlates of multicultural competence. Finally, 21 articles (41%) were

evaluative in nature, focused on investigating the utility and effectiveness of various training interventions used to increase multicultural competency in graduate students. The systematic analysis yielded results that were organized into the following categories: 1) intergroup contact and cultural competence, 2) cultural humility and cultural competence, 3) intersectionality and cultural competence, and 4) antiracism and cultural competence. This review will continue to use the definition of cultural competence espoused by the NASW, which defines cultural competence as including: (1) the awareness of how diverse populations experience their uniqueness in a larger context; (2) an understanding of intersectionality that examines oppression, discrimination, and domination; and (3) a recognition of the individual's position of prerogative and entitlement in relation to the populations they serve and with a recognition of the need to exercise cultural humility (Lusk et al., 2017).

Intergroup contact and cultural competence

Intergroup contact, based on Allport's contact hypothesis (1954), argues that positive contact with an outgroup member can lead to positive attitudes toward the outgroup (Allport, 1954; Imperato et al., 2021). This kind of contact provides the basis for effective communication between groups which may lead to increased cultural knowledge, more accurate beliefs about the other, and an overall gained respect for the outgroup (Kormos et al., 2014). Intergroup contact, within clinical science, may offer a tool for clinicians in training to foster their cultural competence when didactic methods of instruction are insufficient or hold the potential to engender negative experiences for faculty members from marginalized backgrounds who are often uniquely tasked with being on-the-spot experts on multicultural topics (Dorn et al., 2020).

A review of the literature yielded scholars who presented various ways to conceptualize and implement intergroup contact into curriculum aimed at increasing cultural competence within graduate clinicians in training. Thibeault (2019) furthered the idea of intergroup contact for graduate students within the context of service learning with indigenous populations. Service learning, in this case, refers to an approach that implements learning objectives within community service in order to provide a valuable learning experience for students while meeting the needs of the community. Through this culturally immersive experience with another group, students may learn about another culture, increase their skills in cultural competency, and provide the community the assistance it may need in various projects such as building structures and creating gardens (Thibeault, 2019).

Relatedly, Fondacaro & Harder (2014) presented a training model called Connecting Cultures for promoting cross-cultural immersion and contact regarding working with refugee populations. Using a social justice framework, Fondacaro & Harder promoted a culturally sensitive context in which graduate students engage with refugee communities through community service and professional development to prepare them for intercultural contact. This model promoted the idea of cultural competence as a life-long endeavor instead of an acquired skill, tasking graduate students to continually challenge their beliefs and learn from others about their unique lived experiences by continuously seeking out opportunities to engage with different communities (Fondacaro & Harder, 2014). Lorelle et al. (2021) presented the use of cultural immersion as a way to prompt intergroup contact that can increase individual multicultural and social justice competencies. Lorelle and colleagues argued that seeking out opportunities to engage in collaboration and communication through intentionally putting one's self in a culturally different environment can spark discussion of privilege, oppression, and bias that can increase trainee cultural competence.

A review of the literature also yielded various ways in which graduate training can incorporate intergroup contact into clinician instruction, curriculum, and practice. Shannonhouse et al. (2018) investigated the use of cultural immersion and intergroup contact among graduate students in Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited programs. Establishing baseline data regarding how cultural immersion is conducted in counselor education, results from a survey disseminated to program directors indicated that nearly half of respondents' programs engaged in cultural immersion, though they varied widely in the degree to which they facilitated conditions for successful intergroup contact (e.g., providing sociohistorical context, sustained duration of immersion, diverse opportunities to interact with the community, and reflection), implemented evaluation of program effectiveness, and/or engaged students in reflection. Survey results additionally indicated that graduate programs may have a limited understanding of cultural immersion outcomes among their students (Shannonhouse et al., 2018).

Bolea (2012) presented a curricular approach that utilized service learning with indigenous populations as a cross-cultural immersion tool to build cultural competency and critical thinking. Preliminary qualitative findings through anecdotal reports and a course specific evaluation survey showed students reporting increases in empathy for indigenous communities, improved knowledge about the sociohistorical context of the community, and improved relational skills to be an effective social worker (Bolea, 2012). McDowell et al. (2012) examined the use of intergroup contact by investigating student experiences following engagement with an international study abroad course designed to increase cultural competence within counseling students. Following semi-structured interviews to gauge student experience and feedback, results showed increased social awareness, changes in world views, increased awareness of societal structures, recognition of one's own privilege, and enhanced contextual and systemic thinking.

Platt (2012) engaged marriage and family therapy students in a 5-week Spanish language and cultural immersion program focused on improving clinical service delivery to Latinx communities. The 5-week program consisted of critical dialogues with other students and within the unfamiliar culture, the use of online forums, daily Spanish language courses, and home-stay living arrangements with Mexican host families. Results from student qualitative interviews

following the immersion program indicated an increased awareness of one's own culture, increased complexity in how students perceived Latinx culture, and reports of plans to incorporate knowledge into clinical work by tuning into contextual factors that may influence the community and monitoring one's own biases (Platt, 2012).

Dessel & Rodenbord (2017) conducted a study examining outcomes of a master's in social work (MSW) program that implemented an intergroup dialogue (IGD) course in an urban Midwest MSW program, which was based on Sue's multicultural education model. Pretest and posttest data was collected over the span of two semesters using a survey that measured three domains: social identity awareness, knowledge about inequality, and micro/macro social work skills. Results from paired t-test analyses indicated that students reported statistically significant improvement on several measures of cultural competence, including knowledge of racial inequality, understanding the causes for poverty and economic inequality, and motivation to bridge differences; however, students did not increase their comfort in communicating with people of other groups or dealing with conflict (Dessel & Rodenbord, 2017).

Parikh et al. (2020) implemented the use of digital storytelling as a way to immerse students in a culture different form their own. Students were tasked with engaging with a 10-hour mini-immersion experience in which they were tasked with interviewing members of a culture different from their own. Results from qualitative interviews revealed an increased awareness about other cultures, an increase in knowledge of other cultures and their own racial identity, and development of skills in multicultural competence.

Toporek & Worthington (2014) implemented a service-learning program called Project Homeless Connect (PHC), a service that offers employment counseling to individuals from low socioeconomic backgrounds while providing counseling training aimed at increasing cultural and structural competence around impoverished communities in counseling students. Results from qualitative interviews showed students reporting a broadening of their understanding of homelessness, increased self-efficacy from collaboration with community members, and increased confidence in applying counseling skills.

Killian & Floren (2020) explored the relationship between teaching methods and multicultural and social justice competencies within clinicians in training through the implementation of a quasi-experimental study that assigned students to different cultural competence courses. Results suggested that pedagogical approaches that utilized direct exposure, such as community service learning, best facilitated clinician self-reported cultural competence and readiness to be social advocates (measured as 6 levels of empowerment to enact change at the intrapersonal and global level) for marginalized populations, supporting the use of immersive experiences in promoting multicultural competence within clinicians in training.

Lee (2014) implemented a virtual community exercise in order to increase graduate clinician self-awareness of bias and engagement with issues of diversity in relation to marginalized communities through a simulated immersion exercise. A virtual community is a computer-generated display that allows users to feel present and interact with a simulated environment. Qualitative interviews as well as independent t-tests comparing student scores on the multicultural awareness, knowledge, and skills survey (MAKSS) were conducted to determine intervention effectiveness. Results indicated statistically significant increases in learning about diversity concepts, statistically significant increases in self-awareness of perception of issues related to marginalized individuals, and reports of understanding of issues related to one's own identity and community.

Cultural humility and cultural competence

Cultural humility is defined as critical self-reflection of how one's own culture and identities inform how clinicians view clients, emphasizing the role that systems of power and oppression have in shaping individuals' experiences (Abe, 2020). Cultural humility aims to go beyond definitions of cultural competence that only emphasize working across difference by also focusing on an awareness and knowledge of how societal structures and institutions have been organized in a way that engenders inequality (Fisher et al., 2015). Within clinical science, cultural humility may help broaden trainees' understanding of their marginalized clients' lived experiences by tasking clinicians in training to critically examine their own biases potentially increasing opportunities to minimize harm while striving to obtain accurate representations of client experience and psychopathology (Fisher et al., 2015).

Holyoak et al. (2020) attended to critical examination and self-reflection by presenting the importance of the clinician-in-training's "way of being" within family therapy. This "way of being" framework emphasized helping graduate trainees to conceptualize clients as fully human and complex (i.e., seeing clients as individuals with rights, desires, and cultures that have consequences for therapy outcomes), and viewing their clients from a culturally sensitive and humble space while reflecting on the cultural misunderstandings that may arise in treatment.

Stabb & Reimers (2013) spoke to the importance of cultural humility as it relates to working with low-income populations through their presentation of how the APA Training Council Benchmark Competencies can be integrated when conceptualizing graduate training for working with impoverished individuals. Stabb & Reimer argued that a clinician's professional identity should be driven by critical self-assessment and cultural humility. Accordingly, they recommended that clinicians in training be educated on the structural causes of class inequality while engaging in difficult dialogues (focused on issues of class and privilege) within the classroom that hold the potential to build clinician empathy for their marginalized clients.

Trinh et al. (2021) argued for the implementation of cultural humility within psychiatric education, arguing that lifelong engagement with self-evaluation and self-critique within the context of the client-patient relationship is necessary

for understanding how systemic and social structures affect the lives of marginalized clients. By reflecting on personal sociocultural identities, biases, and assumptions, clinicians in training may be able to improve their understanding of diverse patient populations and improve the delivery of mental health care to marginalized individuals (Trinh et al., 2021). Venner & Verney (2015) acknowledged that critical self-reflection and engagement with difficult topics of privilege and oppression can oftentimes engender reluctance and hesitance within clinicians in training. Through the building of trust and rapport, instructors can create conversations that utilize open-ended questions to draw out students' perspectives and goals, aiding students in engaging with topics of multiculturalism within a safe and supportive environment (Venner & Verney, 2015).

Chan et al. (2018) addressed the importance of counselor educators assisting their students in understanding their own privilege by attending to systemic issues of power that have real mental health implications for marginalized individuals. Educators, according to Chan, should communicate to students that although they did not actively create the privilege or discrimination that other groups experience, it is their duty to understand how systems of oppression create sociopolitical forces that affect relationships, services, and advocacy that clinicians provide their clients. Relatedly, Estrada et al. (2013) identified student understanding of privilege as an avenue for promoting socially just practice within clinical work. They presented a student orientation training model involving a mandatory orientation for incoming counseling students, which consists of various icebreakers and group activities. They shared meals aimed at teaching individuals how to recognize their own privileges within an environment that normalizes these discussions and provides constructive feedback.

Dessel et al. (2019) advanced the need for critical self-reflection and cultural humility within the context of training conservative Christian counselors to engage with ideas of power and privilege when working with LGBTQ clients. They argued that faculty can prepare themselves to teach LGBTQ subject matters to graduate trainees by engaging in critical self-assessment and developing knowledge about power and privilege prior to classroom instruction. This may allow faculty to create an environment that empowers students to reflect on their own journeys toward LGBTQ cultural competence (Dessel et al., 2019).

Ridley et al. (2021) introduced the process model of multicultural competence, a framework that advances the intentional integration of cultural knowledge acquisition and understanding within the standard therapeutic goals. Ridley and colleagues argued that a process model of cultural competence promotes an ongoing commitment to cultural understanding, deviating from a content-focused model that may lead to stereotyping once it is "achieved." By continuously engaging in self-awareness of one's own limitations in understanding the complex systems of oppression and power that individuals must navigate, one can continuously strive for education and knowledge acquisition that can improve care for marginalized clients (Ridley et al., 2021).

Our review also yielded descriptions of applications of cultural humility into graduate training for increasing cultural competence when working with marginalized individuals. Tormala et al. (2018) documented how they translated the outline for cultural formulation, an outline within the DSM-V describing cultural factors that may influence client functioning and the therapeutic relationship, into an assignment to increase cultural humility in graduate students. Thematic analysis was then used on both cultural formulation assignments, yielding 6 themes that were analyzed for changes over time: 1) cultural self-awareness 2) intersectionality 3) perspective taking 4) unsupported cultural statements 5) scientific mindedness and 6) power/privilege differentials. Results from these analyses showed increased cultural self-awareness and decreased use of biased cultural statements (i.e., stereotypical or overgeneralized statements) at the end of their academic semester relative to their levels at the beginning of the semester.

Jones et al. (2016) implemented a pilot intervention aimed at increasing cultural competence, knowledge, and self-awareness of graduate clinicians in training. Students in a control group were trained in traditional cognitive behavioral therapy (CBT) frameworks, while separate treatment group received additional instruction that included cultural frameworks and treatment perspectives that were guided by culturally responsive care specific to working with marginalized clients. Results indicated little change for the CBT only group, though the CBT + cultural responsiveness training group showed improvements in cultural competence over time.

Jones & Lee (2021) introduced the use of a one-semester course following Sue et al.'s three domains of cultural competency (awareness, knowledge, skills) in order to increase student cultural competency for working with marginalized individuals. The required multicultural course comprised building student self-awareness through engagement with ideas of privilege, oppression, and color-evasive racism. Results from a pretest-posttest design study utilizing the self-assessment of multicultural awareness, knowledge, and skill (SAMAKS) indicated statistically significant increases across all three areas of cultural competency within clinical trainees with large effect sizes at the completion of the course (Jones & Lee, 2021).

Hoke & Robbins (2011) presented an educational approach that was implemented with beginning graduate psychiatric nursing students with the goal of promoting cultural competence and cultural humility. This educational intervention consisted of integrating cultural competence within a graduate community mental health nursing course, with the expectation that at the end of the course, students would demonstrate understanding of one's own cultural beliefs as well as the cultural beliefs of others within the mental health care setting. Results from qualitative student interviews indicated that students felt they had become more aware of how cultural factors (their client's as well as their own) may affect the nursing care they provide (Hoke & Robbins, 2011). Killian & Floren (2020), mentioned above, also reported within their study that students who completed the multicultural counseling inventory and reported engaging in self-reflection practices demonstrated statistically significant

increases in clinician cultural competence.

Intersectionality and cultural competence

Intersectionality is a theoretical framework for understanding the diversity of experiences of privilege and oppression within groups, with particular attention placed on how marginalized individuals belonging to more than one marginalized group navigate interlocking systems of power and subordination (Bubar et al., 2016; Crenshaw, 2017). Within clinical science and clinician training, this theoretical conceptualization is meaningful because it provides a lens for how educators can address patterns of institutional oppression their clients' experience. Additionally, an intersectional approach to graduate instruction may allow clinicians in training to engage in dialogue and research that highlights the intersection between privileged and oppressed identities marginalized clients hold (Chan et al., 2018). Understanding client experiences of oppression may aid in clinician understanding of factors that differentially lead to negative developmental and mental health outcomes for singularly and multiply marginalized individuals.

The current review yielded scholars who presented various conceptualizations for integrating an intersectional lens within graduate training in the mental health care professions. Rosenthal (2016) noted the common trend for intersectional scholarly work to focus on identities of marginalized individuals rather than on the social inequities they experience, suggesting that intersectional scholarship should attend to the social justice core of intersectionality and work to reduce structural oppression that affects the well-being of marginalized communities. Rosenthal presented several ways that mental health practitioners can make social justice and equity more central agendas in their work, including addressing and critiquing social structures and engaging and collaborating with local communities. Buchannan & Wiklund (2020) provided further critique, positing that while intersectionality is a core competence for mental health practitioners, most graduate programs fail to integrate feminist, critical race, and social justice theories within their curriculum which are pivotal for teaching intersectional competence. Buchanan and Wiklund (2020) presented various methods for incorporating concepts of intersectionality within education and graduate training, including conducting an audit of syllabi to determine if intersectional scholarship is present; establishing a social justice and diversity practicum/specialization; and diversifying the clinical psychology workforce. Grzanka et al. (2021) go further by presenting a conceptual framework for combatting White supremacy through an interdisciplinary intersectional approach, arguing that mental health workers must adopt a commitment to critiquing and transforming oppressive systems. Grzanka et al. provide various recommendations for combatting White supremacy by leveraging current multicultural approaches to clinical work, including utilizing intersectionality to understand clients' relationships to structures of inequality and incorporating interdisciplinary scholarship within intersectional approaches. Gutierrez (2018) furthered the importance of integrating an intersectional lens within the supervisory relationship between clinician in training and instructor. Gutierrez posited that culturally competent supervision involves a responsibility from the supervisor to help students recognize how multiply marginalized clients experience various cultural interactions and systems of power, and aiding supervisees in understanding how their own privilege, biases, and worldviews can influence how they conceptualize and understand multiply marginalized individuals' mental health outcomes (Gutierrez, 2018).

Greene & Flasch (2019) presented a developmental model for integrating intersectionality into clinical supervision in order to foster multicultural competence within clinicians in training. They posited that intersectionality should be integrated into each level of supervisee development to promote a healthy working alliance with clients. This consisted of instructors initiating the conversations about diversity and intersectionality during early stages of student development and transitioning into challenging students to present their own understanding of how client experiences of intersecting systems of power and oppression create unique lived experiences that must be considered for case conceptualization (Green & Flasch, 2019).

Rio (2017) presented considerations for how to integrate an intersectional lens as instructors aim to implement anti-oppressive and liberatory praxis in the classroom. Rio warned about potential issues that may arise when attempting to integrate an anti-oppressive and intersectional approach, including reification of stereotypes by focusing on the "minority client" during discussions of cultural competence. Additionally, Rios spoke to various elements that should be implemented when teaching with an intersectional lens. This included curating a diversity of voices in course syllabi, including content that is pertinent to current events, presenting content aimed at engaging in critical thought and resistance to privilege, and educator preparedness for creating safe spaces for engaging with difficult dialogue that can yield various emotional reactions from students (Rios, 2017). Chan et al. (2018), mentioned in the previous section, also argued that utilizing an intersectional framework may provide a pathway for educators to enhance their students' critical thinking about issues of cultural competence by prompting an analysis of the linkages among various identities.

Our review also yielded various ways in which graduate training can incorporate an intersectional lens into clinician instruction. Bubar et al. (2016) conducted a study in which they tasked graduate students to write a paper on the concepts of structural power and professional power using an intersectional lens in order to assess student understanding of these theoretical concepts. Results indicated that students were unaware of how the provider-client dynamic enacts power and privilege onto their clients. Additionally, student language choice and visual representation of oppression indicated a limited understanding of how oppression is multilayered and intersectional. Bubar et al. (2016) posited that student understanding must therefore be increased by providing them the tools they need to consider paradigms in addition to race and class, employing an intersectional lens that allows them to understand their own place in systems of oppression that permeate our society. Hage et al. (2020) provided a theoretical rationale for implementing

social justice practicums (SJP) within doctoral psychology programs, presenting 3 case examples of implementations while discussing considerations and challenges. Hage et al. provided contextual examples using three different academic institutions (Boston College, Springfield College, University of Tennessee) who implemented SJP requisites within their clinical programs; this included courses geared towards preparing students to intervene in the sociocontextual factors that limit community well-being, exploring questions hindering the mental health fields' focus on cultural diversity and social justice, and preparing students to serve as social justice advocates in their varied roles.

Robinson et al. (2016) presented the implementation of an intersectionality assignment designed to create a paradigm shift for students in order for them to incorporate power and privilege into their conceptualization when working with marginalized clients rather than assigning them to siloed identity groups. Students were instructed to read various manuscripts and then tasked to formulate a definition of intersectionality which they would then present to the class. This assignment was paired with an intersectionality exercise in which students received a random identity (with preassigned character descriptions) and were asked to respond to certain statements by moving forward or backward to aid in understanding how power and privilege plays out differently across various co-occurring identities. Reflections from students and instructors showed that the intersectionality assignment and paradigm allowed individuals to view clients as individuals living within an ever-changing environment (Robinson et al., 2016).

Brinkman & Donohue (2020) conducted a study to determine if a course designed to implement an intersectional lens increased student understanding from the beginning to the end of the term. The course was designed to integrate advocacy to promote systems-level changes and engagement and utilized the awareness, knowledge, skills, and action framework proposed in the Multicultural and Social Justice Counseling Competencies (MSJCC) while introducing the students to intersectionality theory. Quantitative results from this pre-/post- assessment study showed that students showed statistically significant increases in cultural competence and their self-efficacy in examining clients' multiple social identities in their conceptualization of them; additionally, qualitative interview results showed students reported initially not understanding intersectionality.

Nagy et al. (2022) implemented a training curriculum designed to introduce the history of multiculturalism and how the intersection of multiple identities leads to unique lived experiences. Trainees were introduced to the cultural formulation interview of the DSM-V and, through a process-oriented model, were taught how to flexibly respond to salient cultural content and view treatment as a dynamic process that can be influenced by cultural context at various stages. While the study sample size prevented analysis of statistically significant changes over time, results showed increases in mean self-rated cultural competence from the beginning to the end of the course. Additionally, qualitative data at the end of the training showed participants reporting a desire for multicultural training to be infused in other parts of their professional education beyond training.

Antiracism, social justice, and cultural competence

Antiracism can be defined as practices that promote racial equity and actively oppose racism through changes in policies, behaviors, and beliefs that perpetuate racist ideas and actions (Toraif et al., 2021). Antiracist teaching aims to create equitable education for students from all cultural groups, fighting for racial justice and reducing societal inequities that societal institutions perpetuate (Lawrence & Tatum, 1997). Within clinical science, antiracism strives to correct the homogenization of curriculum that prioritizes White voices and excludes marginalized communities by meaningfully incorporating teaching that depicts the lived experiences of marginalized groups (Haskins & Singh, 2015). A related concept, social justice has the aim of achieving full and equitable participation of all groups within a society that is structured to meet everyone's respective needs (Bell, 2016). Clinical work with marginalized individuals often involves helping clients navigate a world that was designed to enact harm and perpetuate inequality, and thus should also involve combatting systems of power that create environments that harm clients (Sheely-Moore & Kooyman, 2011).

The current review yielded scholars who presented various ways to conceptualize integration of antiracist and social justice ideologies within clinical training. Galan et al. (2021) argued for consistent efforts to be taken up by the mental health fields towards dismantling policies, practices, and systems that have contributed to racial inequities in clinical science, training, and practice. Galan et al. provided recommendations for structural reform in regard to clinical training and supervision, curriculum and pedagogical approaches, as well as graduate recruitment and retention. This included requiring trainees to complete training in treating racial trauma; establishing and maintaining inclusive clinic procedures; implementing innovative evaluation strategies for measuring cultural competency; and increasing the use of telehealth services to provide accessible options to marginalized clients. Haskins & Singh (2015) presented the integration of critical race theory (CRT) as a framework for promoting antiracist and equitable training within counseling psychology. They posited that educators should strive to investigate how racism and intersectional systems of power may influence their curriculum and their teaching practices. The integration of CRT within curriculum development and implementation may allow students to engage with curriculum that will uplift the voices of marginalized populations, prepare them to identify and address oppressive environments, and better prepare them to work with marginalized individuals.

Several scholars have furthered the idea of structural rather than cultural competence when understanding the lived experiences of marginalized clients (Ali & Sichel, 2014; Hansen et al., 2018; Metzl & Hansen, 2018; Waite & Hassouneh, 2021). Presented within the context of psychiatry, structural competence goes beyond identifying clinician bias and improving communication, pushing clinical providers to 1) understand how social, economic,

and political systems produce mental health inequalities in marginalized groups and 2) work to correct these conditions (Metzl & Hansen, 2018). Kirmayer et al. (2018) presented structural competency as pivotal for addressing not only the biological bases of mental illness, but also the social and cultural factors that contribute to psychopathology within marginalized groups. Kirmayer and colleagues argued that clinicians should engage in advocacy outside of the therapy room, understanding the structural determinants that inform client mental health and then supporting coalitions and collective actions aimed at correcting the inequalities that lead to further harm.

Ali & Sichel (2020) spoke to how structural competence can provide a framework for linking psychological practice and social justice. They argued that often, the goals of psychological practice and social justice are at odds with each other (i.e., small group change focus vs. systemic change). Ali and Sichel posited that clinicians can be prepared to integrate structural competence while maintaining their efforts for person-level transformation. This may entail 1) actively understanding the political and social landscape in this country, 2) teaching trainees how a lack of access to resources may lead to negative outcomes in marginalized communities, and (3) engaging in community activism that can lead to greater awareness of the lived experiences of different cultural groups.

Sudak et al. (2020) identified the ways in which psychiatric education institutionally disenfranchises marginalized groups through biases in diagnoses, structural racism in recruitment, and inadequate faculty efforts to prepare students to work with marginalized groups. Sudak and colleagues presented the inclusion of cultural and structural competency trainings as a method to improve the inequity that exists in mental health treatment. Structural competency, in this case, involves a shift from instruction that emphasizes cross-cultural understanding to pedagogy that aims to instruct on the societal and institutional forces that contribute to the mental health of marginalized groups (Sudak et al., 2020). Relatedly, Sheely-Moore & Kooyman (2011) argued for the use of a developmental framework to instill social justice competencies in clinicians in training. They described how clinicians in training should engage with a social action plan, focused on identifying how personal privilege as well as systems of oppression inform how they conceptualize and understand their marginalized clients' experiences of violence and marginalization.

A review of the literature also yielded various ways in which graduate training can incorporate antiracism and social justice into clinician instruction. Brinkman & Hirsch (2019) furthered the idea clinical training should empower students to engage in social justice through the identification of and resistance against oppressive forces. They implemented a study that utilized an advocacy proposal assignment which tasked students with reflecting on a form of oppression and developing a realistic plan to effect change. Results from paired-sample t-tests revealed that the students who completed this assignment had statistically significant increases in their intentions to engage in advocacy as well as their confidence to engage in activism when compared to the control group. Student education that informs them about the institutions that create inequality may serve as a catalyst for counselors to not only focus on individual intervention but on actively changing institutions.

Lenes et al. (2020) worked to promote antiracism within clinical training by presenting a training model that paired multicultural instruction with mindfulness activities. The Color Conscious Multicultural Mindfulness (CCMM) training involved multimodal multicultural content delivery (e.g., videos, art, etc.) which was paired with mindfulness practices to aid participants in reflecting on their emotional reactions to content before they responded. Results indicated that the training model ultimately led to statistically significant increases in multicultural awareness, decreases in color-blind racial attitudes, and increased mindfulness practices. Presseau et al. (2019) investigated student reporting of how integrating multiculturalism and social justice within clinician training environments may inform their social justice attitudes and behaviors. Results from this correlational study indicated that students who underwent social justice and multicultural training were more likely to score higher on a social issues and advocacy scale (comprised of political and social advocacy, political awareness, social issues awareness, and confronting discrimination), suggesting that social justice advocacy may be a natural extension of multicultural competence. By revealing how multicultural competence may extend into anti-oppressive educational and practical opportunities for clinicians in training, Presseau and colleagues furthered the idea that prioritizing multicultural competence training within a social justice environment may allow students to become more comfortable with integrating social justice advocacy within their professional identity.

Rohrbaugh et al. (2019) introduced the Yale Department of Psychiatry Structural Competency Community Initiative (YSCCI), an educational approach designed to introduce psychiatry students to the daily lives of individuals in the community and the structural challenges to mental health they face. This approach is comprised of four components: 1) residents, peers and community leaders form teams and discuss challenging topics, 2) small group leaders lead a tour to experience barriers to safe housing, healthy food, and jobs, 3) students are tasked one week later to present their neighborhood experience with a structure al focus, 4) separate focus groups provide an opportunity for feedback. Results from qualitative interviews indicate students found the experience meaningful; reported deeper appreciation for social determinants of health; and increased engagement with issues of power, hierarchy, and systemic oppression (Rohrbaugh et al., 2019).

Mathis et al. (2019) introduced a drawing exercise for increasing structural competence within psychiatry residents. This consisted of an introductory exercise that tasked psychiatry residents to draw the neighborhoods where they grew up, followed by drawing their patients' neighborhoods, highlighting the factors that impacted their patients' and their own health. Psychiatric residents reported an increased frequency of discussion of social determinants of health after participating in this activity, indicating a more nuanced understanding of the structures that affect their patient's physical and mental health outcomes (Mathis et al., 2019).

Gomez (2022), delineating the lack and need for diversity within psychology, presented a case example of a graduate course within her department which served as a foundation for understanding and dismantling structural inequality by adopting an interdisciplinary perspective. The semester long course tackled topics of structural inequality, critical race theory, queer theory, and highlighted the structural inequities within the mental health field. The ultimate aim of this intervention was a shift to a non-pathologizing conceptualization of marginalized individuals affected by intersectional systems of oppression.

Discussion

This systematic review aimed to take inventory of recent publications addressing the conceptualization of cultural competence (with attention to power, privilege, and oppression) and recent efforts to implement and evaluate cultural competence trainings for graduate trainees in the mental health care fields. Accordingly, this review attended to conceptualizations of cultural competence as well as documentation of implemented training interventions and attempts at evaluation of these interventions. Below we highlight key takeaways from this review, identify existing gaps, and make recommendations for how to move the field forward.

A common theme across the articles reviewed was the importance of adopting a conceptualization of marginalized clients' experiences that accounts for the systems of power and oppression that impact marginalized clients' lived experiences. For example, the structural competence approach pushes for clinicians to understand how social structures influence client access to resources, economic opportunities, and susceptibility to experiencing violence (Metzl & Hansen, 2018). This direction in theoretical considerations for culturally competent care goes beyond acknowledgement of difference by incorporating an interdisciplinary lens that accounts for social structures, cultural systems, and historical contexts that influence the lived experiences of marginalized populations. Multiple social structures may also have a concurrent influence on the lived experiences of marginalized individuals. Scholars have attended to the role of multiple intersecting structures of power, arguing that understanding how each client uniquely experiences oppression through multiple intersecting power structures may improve their understanding of the factors that contribute to different mental health outcomes for multiply marginalized individuals (Chan et al., 2018). The literature highlighted various techniques to increase an intersectional structural lens within graduate curricula, including diversifying the authors included in course syllabi, relating class content to current sociopolitical events, and the preparation of a safe space for engaging with difficult dialogues (Rios, 2017). Additionally, it is possible that these findings may have relevance for clinical training globally as racism and other forms of oppression exists in many forms across the world.

Within the training context, the integration of a structural approach includes having students engage with literature that bolsters their understanding of the sociopolitical landscape in a national and local sense so that they can acknowledge how disparate access to resources can contribute to negative outcomes in marginalized clients. Adopting a structurally competent approach to clinical care may require students to engage in critical self-reflection and humility about their own gaps in knowledge, biases, and cultural identities (Abe, 2020). Pushing students to think critically about their own identities, learning, and experiences can solidify concepts and ideas of oppression and power that influence their clients' lives (Hicks et al., 2019). Furthermore, education is posited as a lifelong commitment, given that marginalized clients exist within an everchanging environment and there may always be gaps in clinicians' knowledge of how other cultural groups navigate systems of power and oppression (Fondocaro & Harder, 2014).

The challenge then exists for training programs instructing students with a structural competence lens to move beyond appreciation of the importance of these issues and understand when and how to address these issues within clinical work. It is much easier to keep discussions of privilege and oppression in the abstract while empathizing with marginalized clients about their different lived experiences. It is much more difficult to explore how these issues of marginalization and hierarchies of power influence the therapeutic relationship and clients' perception of mental health care. Furthermore, clinicians in training should be prepared to acknowledge and discuss how current events related to different systems of power (e.g., race related hate crimes, debates about civil rights legislation) may influence their clients' lives (Cardemill & Battle, 2003). Graduate programs and clinicians in training must understand that failing to discuss and address societal issues in the context of psychotherapy may unintentionally invalidate clients and harm the therapeutic relationship.

Students may also be encouraged to engage in antiracist and social justice action in their communities in attempts to mitigate the structural oppression their clients face (Ali & Sichel, 2020). Clinicians working with marginalized clients may find themselves at a loss as they attempt to help clients cope with a larger social environment that is organized to prevent their access to resources, opportunities, and basic necessities. Clinicians striving to adopt a structurally competent approach to clinical care may benefit from incorporating a social justice orientation into their core mission. This would involve going beyond acknowledgment of systemic injustices and adopting a professional responsibility to affect change at the societal level (Alegria et al., 2022). Scholars have argued for clinicians to engage in advocacy work outside of the therapy room, educating themselves on the structural forces that influence their marginalized clients and then supporting collective action (e.g., community service, campaigning, protesting) aimed at correcting these injustices (Kirmayer et al., 2018, Sheely & Kooyman, 2011). Clinicians in training may benefit from instruction that bridges psychological practice and social justice advocacy, preparing them to aid marginalized individuals while becoming agents of change that can help to ameliorate these oppressive environments.

Recommendations

The current review indicates that there may be growth in the attention to the role of power structures in conceptualizations of cultural competence. However, in reviewing articles for inclusion, many articles were excluded because they relied on definitions that focused primarily on difference without attention to power, privilege, and oppression. A failure to incorporate a structural approach to cultural competence may lead training programs to prepare trainees to utilize therapeutic tools (e.g., cognitive restructuring, exposure techniques, mindfulness) in a way that is unintentionally harmful. For example, instructing students to prepare clients to adapt to harmful social environments (e.g., restructuring experiences of discrimination) without acknowledging the larger social injustices that are in need of change may lead clinicians to be complicit within these systems of oppression.

Unfortunately, there does not appear to be much standardization in how mental health training programs define or implement cultural competence trainings (Benuto et al., 2018). Cultural competence definitions have evolved over time but not necessarily linearly or uniformly. Cultural sensitivity and cultural humility have emerged as part of these evolving definitions with a move to center clinicians' awareness of their positionality and biases as well as growing attention to differences within groups as well as between them (Hook et al., 2017; Kumpfer et al., 2002). Yet our review of the recent literature suggests that mental health programs are still struggling to incorporate ideas of power, privilege, and oppression within their understanding of culturally competent care (Metzl & Hansen, 2014). Variability within conceptualization may lead to inconsistent design and applications of cultural competence trainings within graduate school curricula.

Regarding training interventions, our literature review suggested that many programs continue to rely on a single course to teach students about diversity science and cultural competence (Bubar et al., 2016; Hoke & Robbins, 2011; Jones et al., 2016; Jones & Lee, 2021; Nagy et al., 2022; Robinson et al., 2016; Tormala et al., 2018). Single-course approaches to cultural competence training have been shown to be insufficient and fail to integrate necessary content throughout students' coursework and training and neglect to reinforce critical skills (e.g., initiating difficult conversations with clients, reflecting on one's own biases, etc.) throughout students' academic and clinical trajectory (Anderson et al., 2022). Moreover, single-course approaches may inadvertently promote the idea that cultural competence is a merit to be achieved rather than a lifelong journey that clinicians must constantly reinforce through education, self-introspection, and practice. More contemporary conceptualizations of training advocate for a developmental sequence of multicultural competence which targets student's awareness earlier on and then progresses towards a focus on knowledge acquisition and skill development throughout their academic program (Bardone-Cone et al., 2016).

Additionally, the literature emphasized interventions geared toward instilling cultural competence within graduate trainees such as cross-cultural immersion, exposure to marginalized communities, self-reflection exercises, social justice advocacy assignments, and community service learning (Brinkman & Hirsch, 2019; Jones & Lee, 2021). Many interventions aimed to increase awareness of the role of systems of power and oppression, as well as one's own biases toward marginalized groups. It is worth noting, however, that well-intentioned interventions, such as immersion activities, may have the potential to be exploitative. Depending on the approach implemented, immersion activities may further marginalize marginalized communities by using them as tools for instruction. Moreover, if conceptualized or implemented improperly, these types of activities may reify stereotypes or neglect within-group variability, which would undermine rather than further clinicians' cultural competence capacities.

Furthermore, this review revealed that approaches to measuring and evaluating cultural competence may vary substantially across programs (Bolea, 2012; Brinkman & Donohue, 2020; Dessel & Rodenbord, 2017; Hoke & Robbins, 2011; Jones et al., 2016; Mathis et al., 2019; McDowell et al., 2012). While some measures focused on students' attitudes, self-perceptions, and self-efficacy, other measures assessed specific cultural competence knowledge, awareness, and skills (Sue et al., 1982) that were evaluated using validated and reliable assessment tools (e.g., MAKSS). Assessment tools that measure student cultural competence skills may be of more value for assessing the effectiveness of cultural competence training interventions; however, students' comfort and confidence in their cultural competence abilities seems to be a secondary, but important additional measure. The literature review also indicated that few programs may be using rigorous evaluation methods that include control groups, pre-/post- research designs, and large enough sample sizes to meaningfully and effectively analyze evaluation data (Brinkman & Donohue, 2020; Brinkman & Hirsch, 2019; Jones et al., 2016; Jones & Lee, 2021; Lenes et al., 2020).

To move the field forward, graduate training programs may benefit from a centralized repository which can improve communication across programs and may provide more consistency in how cultural competence is defined, implemented, and evaluated. For example, the APA has disseminated resources for clinicians in training aimed at improving support for culturally competent care, including a multicultural training database and guides for students from marginalized backgrounds (American Psychological Association, 2013). This can be extended further by incentivizing research globally and allowing open communication access between institutions from various nations in order to bolster the availability of culturally and structurally competent training models and evaluation methods. By providing access to resources and the most current research on cultural competence training, best practices can be promoted. This may include providing explicit instruction on how training programs can infuse cultural competence throughout their curriculum to provide many points of intervention (Boroughs et al., 2015). A centralized site could also facilitate the sharing of research methods and data across programs which would allow for analyses to be conducted with data from multiple programs. Lastly, more funding opportunities are needed to better incentivize rigorous research on cultural competence

interventions (Galán et al., 2021).

Conclusion

Clients from marginalized backgrounds navigate structures of power that determine their access to resources, economic opportunities, and basic necessities. Clinical care for marginalized individuals may benefit from a structural approach that accounts for oppressive forces within case conceptualization, treatment implementation, and outcome tracking. Graduate programs contend with the question of how to best prepare students to practice culturally competent care with marginalized individuals. Instilling within graduate trainees the importance of lifelong education, social justice advocacy, and critical self-reflection may prepare trainees to provide effective and structurally competent care. The current review suggests that cultural competence conceptualizations, trainings, measures, and evaluation approaches vary across mental health training programs. We suggest that centralized resources and funding opportunities may be necessary to move the field forward. Finally, we believe that the core themes of the results of this review, such as the importance of taking a structurally competent approach to clinical care, can be applied across contexts and may be of benefit to clinicians across the globe.

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