

Training for overcoming health disparities in mental health care: Interpretive-relational cultural competence

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Abstract

Cultural and racial diversity is increasingly becoming a reality in many countries worldwide, to the extent that most every mental health professional will treat patients from other countries, cultures and or races. Research from both the U.S. and Europe indicates that immigrants and racial minority patients receive a lower quality of care, which may in part be related to a lack of professional competence. Few, if any, professional training programs prepare trainees to work with racial or cultural diversity. Cultural competence training represents an approach to reduce health disparities framed in the context of the conceptual approach to culture, diversity, and difference. This article presents an interpretive-relational approach to cultural competence conceptualized as a process of self-introspection rather than a knowledge gathering. Disparities are understood to stem from both cultural and racial difference, and to that end, the basic concepts of culture and race are defined and their relationship to health disparities explored. Cultural competence training, it is argued, must strive to provide trainees with the tools necessary to overcome the principle barriers to the reception of quality mental health care, and can do so by focusing on the knowledge, skills, and attitudes necessary for this process. Because of cultural differences in the way in which mental distress is experienced, expressed, and explained, and because of cultural variation in the expectations of both course and treatment, clinicians must develop a knowledge base about these underlying mechanisms. As racial prejudice contributes significantly to health disparities, it is essential that training is provided that effectively works to reduce the negative impact of racial prejudice rather than a narrative focused on its suppression.

Key words: *cultural competence; diversity training; transcultural psychiatry; racial prejudice.*

In the face of cultural and racial diversity that is increasingly the reality in mental health care in much of the world, “cultural competency training” (or some derivative thereof) has become one of the most highly recommended means of addressing the challenges that said diversity presupposes (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Qureshi, Collazos, Ramos, & Casas, 2008). The need for cultural competency training in psychiatry is very simply a function of the barriers to quality mental health care for ethnic minority and migration patients. Large scale research reports carried out in the UK (Department of Health, 2003; Healthcare Commission, 2005) and the US (Institute of Medicine, 2002) and diverse studies in Europe (Lindert, Schouler-Ocak, Heinz, & Priebe, 2008) demonstrate that health disparities are present in the mental health care system (see also chapter Schouler-Ocak). That is to say, access to mental health services, entry into the services, diagnosis, treatment, and adherence are all of a poorer quality than that of the “mainstream” white population.

Research on cultural competence in mental health care is relatively scant (Bhui, et al., 2007; Vega, 2005), and would appear to be related to methodological challenges which pertain to the isolation of the “ingredients” that actually impact treatment outcome (Brach & Fraserirector, 2000). Two studies indicate that clients who rate their psychotherapists as more culturally competent are more satisfied with the therapy received (Constantine, Kandaichi, Arorash, Donnelly, & Jung, 2002; Fuertes & Brobst, 2002), although in these studies no objective measure for therapist cultural competence was used. Without specific reference to cultural competence, various studies of some form of cultural adaptation in psychotherapy indicate that treatment that is responsive to cultural difference, in the broadest sense, can be more effective than treatment as usual (Tervalon & Murray-Garcia, 1998). There is no shortage of research indicating that responsiveness and sensitivity to difference enhances treatment, which provides the basis for some of what is presented here. At the same time, most every competency model is predicated on inferences as to what constitutes cultural competence rather than any clear empirical evidence (Omi & Winat).

What remains certain, without or without a formalized research base, is that clinicians need to be trained to work with racial and cultural diversity, although as will be suggested below, “all mental health interactions are intercultural”. That is to say, it will be argued that the competencies discussed in this paper have applicability to everyday work as we propose that cultural competence should be conceptualized as a process of self-introspection rather than a knowledge gathering. We also contend that the most important barrier to effective care is a poor or compromised therapeutic relationship (Lindert, et al., 2008; Qureshi & Collazos, 2011), such that cultural competence training is in the service of developing the capacity to build a solid working alliance with all patients, regardless of cultural or racial background. The same fundamental issues are at play in the work with all patients, even if the disparities diminish as cultural and racial differences between client and clinician diminishes. All mental health care is “multicultural”, because all people are “cultural”, and culture is perhaps best understood subjectively. Each individual has been socialized into a micro-culture, and as such the good clinician is always attending to and able to respond to the particularities of each individual patient, taking context into account; general clinical competence, then, implicitly demands cultural competence.

Some 30 years after Sue et al. published their ground-breaking position paper entitled *Cross-cultural counselling competencies* (1982), there exist a wide array of cultural competence models as well as local training approaches, only some of which have been formally incorporated into the accreditation of professional training programs, as is the case in American psychology (Committee on Accreditation, 2005). The recommendations made in this paper are a response to the continental European context in which cultural competence remains a relatively recent concept, and although recognized, to the authors’ knowledge is not required for accreditation. To that end, the discussion of this paper, although applicable in any sort of training context, is developed with a view to post-graduate, continuing education training.

The basic issues of interest in cultural competence training are (1) that there is considerable variation in how a person experiences, expresses and explains distress as well as in their expectations about treatment, and that (2) clinicians need be mindful that their preconceptions and prejudices may interfere with their capacity to engage with and “see” the patient—are applicable in all clinical encounters.

1. A note on terminology

A central yet perhaps under addressed component of cultural competence is terminological and conceptual; how key terms and concepts are understood largely circumscribe how cultural competence training will be carried out. To that end, in the interests of developing solid training programs, it may be worth exploring some terminological and conceptual conundrums that haunt the field of “transcultural psychiatry”. The specific population of interest (i.e. the population of interest for transcultural psychiatry) itself is rather difficult to specify, as are the operational variables. Culture, ethnicity, immigration, race, poverty, minority status, and social exclusion include some of the primary “factors” or “constructs” or “variables” that are at issue, however, few are well defined, and some, such as race, are hotly contested (Omi & Winat, 1993). Even the specific name of the field is contested (e.g. transcultural or cultural psychiatry; cross-cultural versus cultural psychology; multicultural counselling etc.), and indeed replete with disagreements as to whether they constitute distinct but overlapping fields of study, or, rather are like a rose by any other name. Any of the names listed all focus on “culture”, which raises the question about “race”, further confounding the issue.

The concept of “health disparities” at least as developed in much of the literature differentiates between two population groupings, one of which is identified as subject to systematic disadvantage in mental health care; have and have-nots. In the UK and North America, the “haves” are some variation on “Whites” or “European-Americans” whereas the “have-nots” are generally “ethnic minorities”, “people of colour” or “Black British”. On the continent the “haves” are the “autochthonous” population and the “have-nots” are immigrants. Notwithstanding this differentiation, there are multiple factors related to “health disparities”, which are not reducible to simple and neat categories. Poverty, poor housing, underemployment, irregular immigration status, traumatic experiences, lower education, and other characteristics associated with marginalization are often coincident with immigration or ethnic minority status but by no means inherently related. Most categories used in transcultural psychiatry are problematic, replete with both stricter denotations and broader, more enigmatic connotations. For example, in much of Europe, the term “immigrant” implicitly includes poverty and political instability; “culture” on the other hand, tends to be exoticized and essentially the dominion of the “ethnic other” (as if the European mental health professional’s culture is in effect the default, and invisible at that). Furthermore, much of the study of culture and mental health implicitly assumes both homogenous and

discrete groups. Publications abound that characterize groups according to various dimensions or put them into certain categories (“Counseling Asian Americans” or a recent publication in Science, “Differences between “tight” and “loose” cultures: A 33 nation study”, Gelfand et al., 2011). It is apparently assumed that individuals can be unproblematically identified as a member of a specific “cultural” or “ethnic” group on the one hand, and, on the other, that group membership is in some capacity meaningful in that it confers on a given individual certain characteristics. This would be an example of a “totalizing typology” which implicitly confers explanatory power on the group category in question. Such an approach runs the risk of treating group membership as a psychological characteristic on the one hand, and, on the other, that group boundaries are discrete and unproblematic. In this day and age of globalization, neo-liberalism, and world-wide migrations, the very notion of a discrete and homogenous group is increasingly untenable (Bhugra & Mastrogianni, 2004).

For the purposes of this article, two broad, contested, and decidedly imperfect constructs will be used in the discussion of cultural competence, namely culture and race. “*Culture*” itself would appear to be a more palatable construct, in which health disparities are broadly understood to be a function of “cultural differences” in terms of experience, expression, explanation and expectations related to mental health and its care. “*Race*”, considerably less palatable, is nonetheless increasingly identified as the more basic crucible of disparities, which is related not to “inner” difference on the part of the patient but rather to differential treatment on the part of society, institutions, and clinicians.

Clarification of these two constructs is central to cultural competence, not simply for conceptual elegance but also because both the specific conceptions themselves as well as the differential manner of engagement with the two in and of itself will have an impact on how training proceeds and how one will enact cultural competence. To that extent, prior to entering into the relevant competencies, it may be useful to define the two constructs.

1.1 Culture

Culture is a highly complex construct, to the extent that anthropologists have extensively debated its meaning, use, and relevance to the extent that some even called for its abandonment (Brightman, 1995). Given psychology’s and psychiatry’s penchant for the “scientific method”, culture has often been quantified, however, with no consensus as to what sort of variable it might “really” be. For the purposes of cultural competency training, the culture construct is central, and its conceptualization will inevitably impact many aspects of how clinicians view the very complex and fuzzy relationship between culture, the person, and psychopathology. Because of the relative importance of meaning in clinical communication, the following definition of culture is provided:

“A context of more or less known symbols and meanings that persons dynamically create and recreate for themselves in the process of social interaction. Culture is thus the orientation of a people’s way of feeling, thinking, and being in the world—their unself-conscious medium of experience, interpretation, and action. As a context, culture is that through which all human experience and action—including emotions—must be interpreted. This view of culture attempts to take into consideration the quality of cultures as something emergent, contested, and temporal, thereby allowing theoretical breathing space for individual and gender variability and avoiding notions of culture as static, homogenous, and necessarily shared or even coherent” (Jenkins, 1996, p. 74).

From this perspective, culture is about how we experience and make sense of the world. At the same time culture is not to be reified, or frozen, or even unified. To that end the very notion of “knowing” a culture becomes a highly dubious if not counter-conceptual project, precisely because culture is much more a socially given idiographic process, context, or condition than any sort of knowable entity. Culture is of interest for clinicians in the context of one’s encounter, interaction, interpretation, and sense-making with the world.

1.2. Race

Race is a decidedly contested construct, largely because of its historical association with biology and behaviour. Few would argue that race is a “real” construct at all, however, there is no agreement as to whether it should stand as a category in the human sciences. Concerned about its use to disempower or disadvantage, it is often argued that the construct should be abandoned, yet at the same time, doing so

renders complicated addressing racism, as Smedley & Smedley (2005) argue in an article aptly entitled, *Race as biology is fiction, racism as a social problem is real*. Because of the very strong indications that racism is a central part of health disparities, replacing it with “ethnicity” appears to serve to divert attention from the issue at hand. To that end, the following definition thematizes the dialectical and political nature of the race construct:

“Race is a dynamic set of historically derived and institutionalized ideas and practices that (1) sorts people into ethnic groups according to perceived physical and behavioural human characteristics; (2) associates differential value, power, and privilege with these characteristics and establishes a social status ranking among the different groups; and (3) emerges (a) when groups are perceived to pose a threat (political, economic, or cultural) to each other’s world view or way of life; and/or (b) to justify the denigration and exploitation (past, current, or future) of, and prejudice toward, other groups” (Markus, 2008, p. 654).

Race, then, for our purposes, is strictly a socio-political construct, however, a social construct the very existence of which is predicated on power, on control of, and access to resources. To that end, “races” and their delineation are always political.

2. Background on cultural competence training

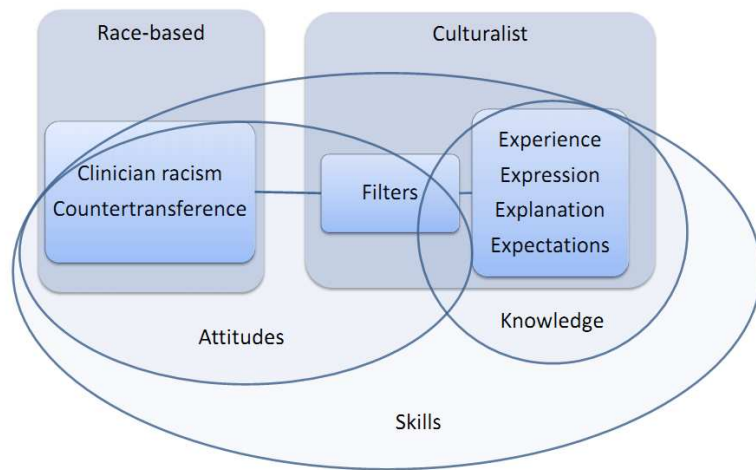
The need for cultural competence derives from the existence of health disparities; patients would receive higher quality treatment were specialists to have better competences. Over the past 30 or so years, a variety of approaches have been taken, which have oscillated between a more “race-based” approach and a “culturalist” approach (Carter, 1995; Carter & Qureshi, 1995). Gregg and Saha (2006) make the very powerful point that disparities are due to both, however, it may be that “race” paradigm is generally eschewed in favour of the culturalist perspective as a means of avoiding the rather more uncomfortable issues related to racism (Helms, 1994; Smith, Constantine, Graham, & Dize, 2008). Present in the overall discourse are differences on both, situating the roots of and solutions to health disparities, as well as more powerful political and perhaps even psychological factors.

The culturalist approach holds that health disparities are largely due to differences in how psychopathology is both expressed and explained. Patients from “other” cultures are misdiagnosed, misunderstood, because their manner of living mental distress is distinct from that standard to Western trained practitioners and to “psychiatry” as a Western phenomenon. The most important manner, then, of reducing disparities from this perspective is by educating clinicians about the ways in which culture influences the experience, expression and explanation of mental distress along with the expectations about treatment, prognosis, and the course of illness. Traditionally, this has often meant focussing on the “cultural characteristics” of the primary patient groups in the region.

2.1 Cultural competence training in a nutshell

Multicultural counselling competency models, like most competence models, consist of the three domains of knowledge or cognitive competence, skills or procedural competence, and attitudes and beliefs or attitudinal competence. Applied to the two health disparity domains identified, “knowledge” is particularly germane to the culturalist perspective, which demands attention to cultural aspects of experience, expression, and expectations, whereas attitudes are particularly applicable to the race-based approach, which demands attention to racial prejudice. Skills are applicable to both the culturalist and race-based approaches. Cultural knowledge, as Sue and Zane (1987) pointed out, is distal from the clinical encounter, and thus must be effectively applied in order to have any therapeutic value. Identification and modification of racial prejudice and ethnic countertransference is a very demanding and complex process, and requires considerable skill for its realization.

Figure 1: Model of Cultural Competence



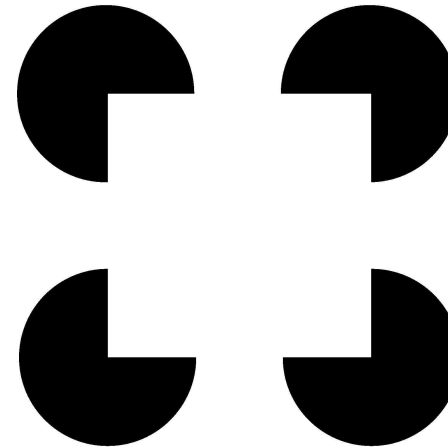
As can be seen in figure one, these three domains consist of both culturalist and race-based concepts that are organized on a non-exclusive fashion. Whereas culture includes what we can call the four axes, all concepts related to subjective experience. Attitudes are more relationally based. Skills involve application of attitudes and knowledge in the clinical context.

3. An interpretive relational approach

Engagement with a patient in the mental health context is both an interpretive and relational experience. On the one hand the clinician seeks to make clinical sense of what the client presents, and, on the other, it is through the interaction—the relationship—with the patient that the clinical process advances.

3.1 Interpretation and hermeneutics

We are interpretive creatures; we are always already in the process of trying to make sense of our world, implicitly, automatically, and unconsciously, a perspective common to both the cognitive sciences (Banaji, Blair, & Glaser, 1997; von Hecker et al., 1997) and hermeneutic philosophy (Gadamer, 1997; Weinsheimer, 1985). We approach any new experience, any stimuli, and automatically organize it into a “whole”; we automatically make sense of it.



If asked what they see in the above image, most people will say they see a square (even if they are aware that there are four $\frac{3}{4}$ circles...). This is automatic, and it is impossible *not* to see the square that “does not really exist”. What this means, then, is that rather than seeing things “as they really are” we see them in accordance with our perceptual devices, on the basis of what is already known, consistent with previous experiences. In contrast with his “grand-mentor” Husserl, who maintained that the knowledge of “essences” would only be possible by “bracketing” all previous assumptions (Husserl, 1913), Gadamer (1960) observed that in the human sciences there exists a “prejudice against prejudice”, inviting scientists to be aware of their prejudices through analyzing the context where they work. Rorty (1987) held that we are all of us “ethnocentric”, that is, we see and experience the world from our own particular perspective. Research in the area of the “social” brain shows that social interaction (which, by definition, is cultural) influences synaptogenesis and synaptic pruning (Dawson, Ashman, & Carver, 2000), to the extent, for example that by one year of age the capacity for hearing language sounds is largely determined (Kuhl, 2010) (see also chapter Han).

3.1 Relational/dialogical perspective

In recent years, something of a “relational revolution” has been taking place in the human sciences, in which the self is understood as fundamentally relational or intersubjective, as opposed to the Cartesian notion of a bounded, in effect “separate” individual (Mitchell, 2000; Orange, Atwood, & Stolorow, 2001; Suchman, 2006; Yonteff, 2002), a perspective that is lent support in the neurosciences in the study of the social brain and mirror neurons (Cozolino, 2006).

A relational perspective holds that in effect, as expressed by the African proverb, “I am because we are, and since we are, therefore I am” (Hord & Lee, 1995). The idea is that humans are always already in relationship starting from our entry into the world (and some would argue that it is also the case during gestation). The perspective holds that it is not simply internal drives or programming, but rather our relational history which in turn impacts our being, at every level, as we saw with the example about language that results in us being who and how we are. As relational creatures, we are not simply onion-like layered selves that have a particular form (though it may be hidden over); how we are at any given moment in time is in part influenced by the specific interaction in which we are engaging. Hubert Hermans, in his model of the dialogical self (Hermans, Kempen, & Van Loon, 1992), defines the self as extending beyond the skin, to the extent that it includes significant and influential others; that which I see and experience is, in effect, part of my self.

For mental health care, one of the strong implications of this approach is that as relational beings, we impact and affect each other. The notion of “mutuality” holds that clinician and patient, in their mutual interaction, have an effect on each other (Aron, 1992; Qureshi, 2005). To that end, a patient’s enactments

in a clinical encounter will in part be related to the nature of the interaction with the clinician. The clinical process, therefore, will require that the clinician attend not only to the patient's symptom presentation, personal and cultural history and the like, *but also to her or his impact on the patient.*

As can be seen, the interpretive-relational approach shifts the vision of our clinical work, to how we engage with the other, and to that extent cultural competence training will be focalized around the development of the therapeutic relationship. Personal experience as trainers as well as some anecdotal evidence indicates that the biggest barriers to cultural competence may indeed be both personal and contextual. Chun (2010), for example, in her discussion of developing cultural competence training for surgeons, notes that she was surprised by the considerable resistance among trainees that she encountered as she attempted to establish an cultural competency training initiative. It would appear that many people overtly assert that they do not perceive such training as valuable. She also observed that people resisted the "self-exploration" aspect of the training, apparently related to the fear that they would be labelled as a "racist". It would appear that a "politically correct" context in which there is strong social pressure to exhibit a specific discourse concerning diversity may serve to impede effective training—or even its delivery.

4. Racism

Research from a variety of fronts indicates that one of the most devastating sources of health disparities is racism (Dovidio et al., 2008; Institute of Medicine, 2002; Kenneth, Klap, Koike, & Sherbourne, 2001; Miranda, McGuire, Williams, & Wang, 2008; Simpson, Krishnan, Kunik, & Ruiz, 2007). Patients receive differential treatment due to their perceived group membership; and in that respect, immigrants and ethnic minorities receive a poorer quality of care. The disparity shows up as poorer access, a lower likelihood of receiving needed care, and when treated, reception of poorer quality of care (Drummond, 1988; Redmond, Galea, & Delva, 2009; U.S. Department of Health and Human Services, 2001; Whaley, 1998).

That health disparities in mental health care are in part due to racism may appear counterintuitive given that mental health professionals are overwhelmingly liberal in political orientation (Redding, 2001), and as such profess a decidedly anti-racist sentiment. At the same time, there is a growing body of research indicating that even the best intentioned amongst us are prone to respond differently to people of different races and backgrounds, showing a preference for people "like themselves" and greater discomfort from those whose appearance is distinct (Dovidio, Gaertner, Kawakami, & Hodson, 2002; Dovidio, Kawakami, & Gaertner, 2002; Greenwald, Poehlman, Uhlmann, & Banaji, 2009; Nail, Harton, & Decker, 2003).

Research in the area of "aversive racism" (Dovidio, 2001; Dovidio, Gaertner, et al., 2002) and implicit attitudes (Banaji, et al., 1997; Greenwald, et al., 2009) differentiate between behaviour that is under explicit or conscious control, and that which is not. A pencil-and-paper instrument that assesses racism is under conscious control, as is any verbalized expression of attitudes. In the mental health profession in particular and in most Western democracies in general, overt expressions of racism are considered to be both personally and socially repugnant. At the same time, and despite the best of intentions, most people express an own-group preference and discomfort and differential treatment of people from "different" racial groups than their own. In effect, our cognitive and emotional processes are impacted by our own histories of socialization in cultures, which denigrate immigrants, and ethnic minorities in contradistinction to majority group members who are depicted as capable and meritorious. The various tests of unconscious racism developed over the past decade or so utilize reaction time, skin conductance and other physiological indicators that are beyond conscious control (e.g. Implicit Association Test, accessible online at the Project Implicit website, <http://projectimplicit.net>). A growing body of research, although small, nevertheless strongly indicates that despite our liberal bent, mental health professionals are as prone to implicit racism as anyone else (Boysen, 2009; Penner et al., 2010; van Ryn & Fu, 2003).

Two related and useful concepts are those of "racial microaggressions" and racial or ethnocultural countertransference. The former concerns behaviours or statements made, in general, by majority group members that are experienced by a person of colour as offensive or hurtful, whereas for the perpetrator the behaviour is viewed as benign (Harris, 2008; Sue, Capodilupo, & Holder, 2008; Sue et al., 2007). In the mental health context researchers have begun to chronicle the ways in which clinicians unwittingly "aggress" against their ethnic minority and patients (Constantine, 2007; Sue, et al., 2007). Included are comments such as "you are a credit to your race", minimization of the patient's experience of racism, a "colour-blind" response to the patient ("I do not notice a person's race, rather who they are as a person").

To that end, a growing body of research associates a colour-blind stance on the therapist's part with lower levels of perceived empathy (Burkard & Knox, 2004) and cultural competence (Beutler, 1981)

"Countertransference" has a psychoanalytic conceptual basis, however, as applied to racial and cultural difference, simply refers to any clinician reactions that are not related to the patient him or herself. Given that racial difference is rife with uncomfortable associations, particularly for liberal clinicians, it is posited that we compensate for the discomfort provoked by race related material by transferring onto the patient a response that is less threatening (Altman, 1999; Comas-Diaz & Jacobsen, 1991; Gorkin, 1996; Holmes, 2001). What this means is that we lose sight of the patient and respond to our projections, even though these may be overtly benign, for example, responding to the patient's culture with considerable interest ("oh, I just love [fill in the blank] culture, it is so interesting").

What all of this means is that our attitudes have a tremendous impact on our clinical work with immigrant and ethnic minority patients, to the extent that the American Psychological Association in their *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, in which the guideline #1 states:

"Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves" (American Psychological Association, 2003).

Addressing race and prejudice in training is complicated, in large part because of the very strong societal taboo that exists concerning race and racism. It is not only the case that we are prejudiced, but also we live in a society in which discussion of "race" is highly controversial, to the extent that many people insist that race does not exist and must not be discussed. From the perspective of training in cultural competence, semantics are important to the extent that they hinder or help in the exploration of and attention to racist and other such beliefs.

4.1 Cultural competence training and race

One of the pitfalls of anti-racism training has been that it has adopted a moral-ideological perspective, in which trainees are told that they are racists and must adopt a non-racist approach (Bennett & Keating, 2009). The impact of such an approach more often than not is to provoke a highly defensive reaction on the one hand, and a rift between the trainee and trainer; the former feels attacked whereas the latter acts as a crusader.

The research reviewed, combined with the interpretive or hermeneutic approach (Christopher, 2001), demonstrates that having prejudices is not "bad", but rather simply part of the human condition. That is to say, training is not about adopting a certain moral stance but rather striving towards maximizing clinical competence. To that end it is recommended that trainees adopt a collaborative, non-judgemental, and supportive stance, providing trainees with a forum in which to express and explore frustrations, difficulties, and fears associated with race and culture.

Effectively addressing such issues in the training context demands the creation of a non-threatening environment in which trainees feel safe to express their "true" feelings. This, in turn, demands that the trainers themselves have engaged in and indeed are engaging in a similar process. One approach is that of the "lab", a sort of group-process, in which trainees are invited to explore their feelings and reactions related to "diversity" (Carter, 2003). A process orientation means that participants are encouraged to explore and process their feelings and thoughts with an eye to understanding how they interfere with clinical work.

5. Cultural filters: Attitudes and humility; knowledge

From the hermeneutic perspective, we see and experience the world on the basis of what we already know, through our interpretive filters. Although much of biomedicine has long staked a claim to "objectivity" and "evidence based" practices, this stance is increasingly questioned (Haraway, 1988; Howard, 1991). If indeed it is the case, as argued here that experience is culturally circumscribed, then it follows that our interaction with the world is always "from our point of view"; that a "bird's-eye" view is simply the perspective of a bird (and not how things *really are*). Following this line, then, comes the

central notion that our experience of and interaction with the world is very much a function of what could be termed our cultural filters, sometimes called worldviews, cultural values, psychological constructs, value orientations, or narratives (Frankl, 1977; Kelly, 1955; Kirmayer, 2007; Koltko-Rivera, 2004).

Taken from this perspective, the Western trained psychiatrist or psychologist will “see” the immigrant patient both from her or his perspective as a “Westerner” and as a psychiatrist or psychologist. Likewise, Nancy Andreasson (2007) recently lamented the “death of phenomenology” given that psychiatrists are trained to identify mental disorders on the basis of the DSM system; our training and the overall perspective taken therein circumscribes how we “see” the patient.

Thus from the very outset, it becomes essential that trainees are willing to accept their “situatedness”, their ethnocentrism, that they see things from a particular perspective, which may constitute the truth in a particular professional context, but not the Truth as it “really is”. Indeed, it is worth noting that the quest for the Truth and the assumption that the Truth can be accessed by way of the correct application of the best practice, are themselves “cultural values”.

The need for perspectivalty is all the more pronounced given the “play” of culture. Knowledge in the cultural competence model presented here is primarily related to the how, or at least possible hows, rather than any concrete “whats”. Thus specific “knowledge” about a given culture *may* be useful, however, only if deployed in a—you guessed it—culturally competent manner. Knowing about the general impact on different facets of life as related to mental health and its care can provide a useful framework through which one can make sense of things. It is worth noting that as clinicians we can be aware that culture impacts experience, expression, and explanation of mental illness and distress *in general*, but we cannot know “how” or even “what” only knowing a person’s cultural membership. It makes no sense to say that “Nigerians experience anxiety in such and so a way”, or that “Germans express social stress in such and so a way”. What we can say is that a given individual’s experience is culturally circumscribed something that I need to take into consideration as I attempt to diagnose and treat this patient.

5.1 Experience

In a rather provocative statement, metaphor commentators Lakoff and Johnson (1980) argue that we never experience “the things themselves”, but rather do so culturally:

“... every experience takes place within a vast background of cultural presuppositions....Cultural assumptions, values, and attitudes are not a conceptual overlay which we may or may not place upon experience as we choose. It would be more correct to say that all experience is cultural through and through, that we experience our ‘world’ in such a way that our culture is already present in the very experience itself” (p.57).

Second order cybernetics from Heinz von Foerster (1981) could be useful to understand this concept. According to this author “a brain is required to write a theory of a brain”. In other words, whether we realize it or not, when we analyze others we implicitly analyze ourselves.

The current perspective on the interrelationship between “nature” and “nurture”, on the “cultural” or “social” brain provides further weight to this perspective. By now it would appear that we know that our experience impacts our biology, just as our biology impacts our experience. What this means is that experience itself is “cultural”, or to put it another way, there is no such thing as “pure” experience, and our experience is just that; our experience (see also chapter Han).

5.2 Expression

How we express ourselves, our emotion, our distress, even our psychopathology is in large part related to cultural norms (Furst, 2002; Katz et al., 1988). It has been reasonably well established that “idioms of distress” are culturally circumscribed (See also chapter Bäärnhielm). Once again, this is not to say that there is a Spanish way of expressing fear, but rather that what we consider normative for the expression of emotion or distress is exactly that, normative within a particular group. In psychiatry we are alert for “flat affect” “anhedonia” “emotional lability” and a discrepancy between affect and speech content. All of these involve cultural norms, that is, what may be “flat affect” for the emotionally volatile Spaniard may be normative emotional expression for the even-keeled and stoic Swede, if we may succumb to generalizations.

Not only the intensity of expression but also the content of expression is culturally circumscribed. In the West, where the Cartesian mind-body dualism is the norm, psychological expression of distress is pretty much standard. In many parts of the world, however, there is no such dualism, and distress is simply distress, with no clear division between somatic and psychic (Kirmayer & Groleau, 2001).

What constitutes a symptom and how that symptom is related to a given mental disorder also comes into play. In the DSM-IV an appendix includes “Culture bound syndromes” such as *ataque de nervios*, *koro*. These, along with, some would argue, disorders such as anorexia nervosa or borderline personality, comprise culture-specific symptom-pathology matches and constellations that are not universal (Mezzich et al., 1999) (See also chapter Mezzich).

Clearly, there is no way to ascertain a priori how anyone will express their distress, and making sense of said expression is not necessarily all that easy, particularly in the face of cultural difference. No recipe book is available; however, the culturally competent clinician will be interpreting the expression of distress taking into consideration the possible cultural variation therein.

5.3 Explanation

As experience and expression of emotion and distress varies cross-culturally, it follows that the explanations that are given for why distress is experienced do as well (Bhui & Bhugra, 2002; Dinh & Groleau, 2008). How a patient explains what is happening to him or her will in large part depend on his or her world-view. Although there are clear cross-cultural tendencies, one need not travel far—perhaps down the hall—to find different explanatory models (see chapters Bäärnhielm, Balkir). Indeed, in Western mental health we see biological, psychological, social, and systems explanations, with greater or lesser degrees of convergence. That is to say, once again it is not that culture x uses a supernatural explanation for mental distress whereas culture y uses a social one, rather it is a question of tendencies, tendencies that shows specific patterns (McCabe & Priebe, 2004).

This would appear to be all the more pronounced across cultures, such that the source of the problem is viewed very differently. Given the variation in cultural values, and given the modernist paradigm (in which psychiatry is soundly situated), it follows that many patients hold divergently different views on the source, cause, and even nature of their distress.

Perhaps the most relevant here for training are two related issues. One is that a person who says that he or she is ill because of hex, astrology, having walked near a humid zone, the evil eye, and so on is not necessarily “crazy”, simple minded, gullible, or any such thing, but rather may well be expressing and culturally normative way of explaining that one is hungry.

The second is that what constitutes a “symptom” in the DSM-IV may not in another culture. That is to say, the combination of a supernatural based explanation and expression may appear to be symptomatic of mental illness whereas it is simply culturally normative expression and explanation of a non-pathological life situation.

5.4 Expectations

What people expect about their interaction with the mental health professional, the nature of the treatment, and the course of the “problem” can vary considerably, and largely as a function of cultural difference. The very notion of a weekly office visit in which the patient talks about their personal problems with a stranger itself is specific to a particular cultural context.

There is an increased attention to both patient- and relationship-centred care (Suchman, 2006), in which the therapeutic relationship is viewed as collateral and constituted by patient and clinician collaboration, although consistent with the anti-hierarchical and power differential values endemic in many contemporary therapeutic approaches. This tendency runs decidedly against the grain for many from more hierarchical and authoritarian cultures, e.g. to the extent that patients have been known to insist on referring to the psychologist as “doctor”, eschewing the use of first names, and questioning the utility of talking, of a focus on insight, exploration of emotions, experience, and the like (Sue, Ivey, & Pederson, 1996). Many patients specifically expect that their psychologist or psychiatrist will provide them with

advice and concrete suggestions—after all, they are the experts—as to how they can reduce their distress and live more effective lives.

Expectations about the course of the distress can also vary which are often intimately related to the explanation or understanding of the basis of the distress. From a medical perspective, in which illness is a function of some sort of internal biological or psychological dysfunction, the presence of symptomatology at any given moment is not necessarily indicative of an absence of the disease entity; remission does not equal cured. From a “demonic” perspective, this is not necessarily the case; absence of symptoms in a given moment most likely indicates an absence of possession, hex, and so forth. What this means, then, is that a patient whose expectation and understanding of distress diverges from that of Western biomedicine may discontinue treatment not because he or she “lack insight” or is “resistant”, but rather because of cultural difference.

5.5 Training issues in the context of the cultural context of experience, expression, explanation and expectations

The central premise concerning the four exes is that cultural fundamentally circumscribes how a person experiences and makes sense of their distress. A post-modern or relativist perspective would train clinicians to understand that, in the words of George Howard, a demonic or supernatural explanatory model is as valid as a psychiatric one. Although this may make heuristic sense, in our daily clinical work, we are not shamans or mystics but Western trained mental health professionals, meaning that we operate from a fundamentally distinct epistemic paradigm. The challenge, then, is to adopt what Rorty (1986) calls a “benign” ethnocentric attitude. To that end, trainees must learn to appreciate the broad variety of possible ways of experiencing, expressing, and explaining mental distress without opening their minds so much, that, as Rorty laments, their “brains fall out”.

The central challenge is one of self-awareness, of excavating one’s epistemic filter such that one has a sense of “where one is coming from”, while at the same time having the capacity to differentiate between psychopathology and culturally normative behavior. There is no “easy way out” of this conundrum, precisely because what is normal for one person may be downright strange for another. This does not mean, however, that the strange is simply “cultural”—such a stance of extreme relativism can result in severe underdiagnosis. Yet at the same time, there is a very clear risk of overdiagnosis if cultural variation is not taken into consideration.

6. Cultural competency training, political correctness, and stress

In much of the European context, most clinicians’ first contact with “cultural competence training” may well be post-graduate, once they are working in the field. Given the nature of mental health budgets, this all too often also means that they are working under considerable work stress, with a high patient load. When a high patient load is combined with patients coming from other countries and cultures, this can exponentially increment the resultant stress and lead to burn-out.

All too often, the training context is one in which the trainers are implicitly or explicitly proffering the message that they are “less racist”, more “culturally on the ball” etc. than the trainees. The trainer often comes across as holier-than-thou, she or he who spews forth politically correct cant to such an extent and with such fervour that what trainees end up learning is to abide by the cant, by the politically correct narrative. Although this may be vaguely coherent from an institutional demand for compliance with state mandates, it is at best ineffective and at worst counterproductive. The danger of such an approach is that it creates a distance between trainer and trainee, in which the latter is being told (a) that he or she is bad for having racist thoughts or feelings, and, that (b) prejudices must be eliminated completely. Evidently, such an approach is rarely effective. It may change the explicit behaviour; however, the implicit attitudes do not change. What may come up here is that trainers are no more “free” from prejudice than is anyone else. To that end, trainers must always adopt a dose of “cultural humility” (Tervalon & Murray-Garcia, 1998) and recognize that none of us are prejudice free, that we are always responded from our subjective perspective, and simply spouting the “right words” is only operating at the explicit level, and the real change is represented by implicit behaviour change, not just external. This is all to underscore the importance of the creation of an open, safe, comfortable, and collaborative learning environment.

Participants need to feel safe, feel that it is acceptable for them to express their thoughts and feelings. If the message they get is that talking political correctness is what gets valued, then there is little hope of much progress. Getting beyond the prejudice against prejudice is essential, what is important is recognition and acceptance that we all of us experience and interpret the world through our own (prejudiced) filters, and as such the key first step is acknowledgment of this. Therefore, the issue is not that we “should not be prejudiced” but rather that we need to be open to how we engage with the world and actively strive to recognize and reduce the play of prejudice in our intercultural encounters.

7. Conclusions

The main job of the trainer is to create a safe, open space in which dialogue can flow freely, in which participants do not feel judged, do not feel afraid of expressing feelings and opinions that may run counter to those that are socially normative. Our experience as trainers shows that even the most politically committed clinician is at least somewhat ambivalent about these issues, and sharing this ambivalence between colleagues who are committed to providing their patients with a high quality of care is liberating. The discourse then shifts from one of “I shouldn’t feel like this” to “OK, given that I sometimes feel like this, what can I do, as a clinician, to improve the services I provide?”. Cultural competence, as discussed in this chapter, is more concerned with how the clinician interacts with patients than with what she or he knows about the patients’ cultures. It is argued that effective clinical care, particularly when working with patients from diverse backgrounds, demands self-awareness and as such self-exploration. Exploration and interrogation of prejudices allows clinicians greater freedom by which to become aware of and therefore alter those prejudices that impede effective clinical care. Cultural competence is not an end-point but rather a process; not something to be achieved, but rather, in the spirit of cultural humility, an orienting paradigm that allows us to be more effective clinicians.

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