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Running Head: INTEGRATING DIVERSITY INTO THERAPY PROCESSES

Integrating diversity into therapy processes: The role of individual and cultural diversity competences in promoting equality of care

Carla Moleiro, Jaclin Freire, Nuno Pinto & Sandra Roberto

Instituto Universitário de Lisboa ISCTE-IUL, CIS-IUL, Lisboa, Portugal

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Abstract

Background: One of the most significant challenges facing the provision of health care in present societies is the fact that the largest growing segment of the patient population is comprised of individual and culturally diverse people. However, the impact of this diversity on clinician-client interactions has only been examined recently. The present paper addresses the issues of culture and diversity in psychotherapy processes in Portugal.

Methods: The study used an analogue experimental design, in a qualitative analogue study. The sample included 31 psychotherapists of varied years of experience and theoretical training background. Cultural diversity competences were measured with a semi-structured interview, through case conceptualisation and intervention planning by watching 4-minute video case-vignettes with stigmatised-group clients (varying on migration background, religion, race, and sexual orientation), and all female college students presenting the same complaint. Two cases (out of four) were presented to each psychotherapist (at random, controlling for presentation order). Interviews addressed case conceptualization of each of the clients, as well as questions on how the participants typically integrated diversity in psychotherapy practice. Transcripts of the interviews were analysed incorporating features of Thematic Content Analysis and Consensual Qualitative Research.

Findings: Results showed that awareness, knowledge and skills were identified mostly at a level of blindness (n=519; 70.5%) and pre-competence (n=172; 23.5%), while only a few units of analysis were categorized as competent (n=43; 6.0%).

Conclusions: This study highlights the importance of individual and cultural diversity competence training for clinicians, particularly in Europe, given its current migratory context, and encourages the promotion of diversity-sensitive approaches in mental health care.

Keywords: Individual and cultural diversity competences; health care disparities; psychotherapy processes; analogue study.

Introduction

One of the most significant challenges facing the provision of health care in present societies is the fact that the largest growing segment of the patient population is comprised of individual and culturally diverse people (Anand & Lahiri, 2009). Only recently has the impact of this diversity on clinician-client interactions been examined; for instance, in medicine (Hall, Chapman, Lee, et al., 2015; West & Schoenthaler, 2017) and psychology (Carter, 1995; Dovidio, Gaertner & Pearson, 2016; Lago, 2011; Pontorotto, 1988).

Current literature in psychotherapy research does not necessarily portray the diversity of the population (Aisenberg, 2008; Sue & Zane, 2006; Whitley, Rousseau, Carpenter Song, & Kirmayer, 2011). In fact, most studies on basic and clinical psychology are oriented to Western, middle-class, educated young people (Henrich, Heine, & Norenzayan, 2010). Conversely, societies are becoming more diverse, thus increasing specific challenges for intervention. Studies have shown that most practitioners, throughout their careers, will work with at least one lesbian, gay, or bisexual client (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Murphy, Rawlings, & Howe, 2002). Also, this era is characterised by an overall framework where people also view the world through the possibility of moving elsewhere (Esses, Medianu, Hamilton, & Lapshina, 2015). According to the World Migration Report (IOM, 2015), contemporary migration has an unprecedented mobility with an estimated number of 232 million international migrants in the world. This reality increases the probability of potential clients from different cultures around the world. Furthermore, it is predicted that the time psychologists dedicate to older adults will increase due to demographic changes (Karel, Gatz & Smyer, 2012). However, therapeutic practice is challenged by many related variables, such as race and ethnicity, gender identity, ability status, religion, language, and economic and social class (Cornish, Schreier, Nadkarni, Metzger & Rodolfa, 2010).

Diverse and globalised societies raise demographic and socio-political changes. Simultaneously, many individuals experience socioeconomic disadvantage, marginalisation, and oppression (Sue, Arredondo, McDavis, 1992). More than a decade ago, Europe (European Commission, 2004) and the United States (U.S. Department of Health & Human Services, 2008) recognised that minority groups experience more difficulties in accessing and receiving adequate care in the health system, and require culturally competent mental health services. Difficulties are even more significant since these populations are exposed to a higher level of risk factors (prejudice and discrimination) for mental health problems (Zane, Hall, Sue, Young, & Nunez, 2004).

The sources of disparities in health care are complex and exist in a broader historical and contemporary context of social and economic inequality, prejudice, and systematic bias (Sue; Zane, Hall, & Berger, 2009). In fact, “it has gradually been recognised that different axes of social power relations, such as gender, socioeconomic position, discrimination, and racism, are interrelated, not as additive but as intersecting processes” (Iver, Sen & Ostlin, 2008, p. 14).

Some authors (Sue, Arredondo & McDavis, 1992; Hall, 2001) proposed that traditional psychotherapy and counselling were no longer providing an appropriated care to their minority clients, and that psychotherapists’ practices could be considered irrelevant and even oppressive toward the culturally different. Within this perspective, social inequalities in mental health care can no longer be detached from the professionals’ sense of social responsibility and social justice concerns (Gorski & Goodman, 2015; Ratts, 2011; Ratts & Pedersen, 2014; Ratts, Nassar-Mcmillan, Butler, & McCullough, 2016). The goal of social justice is to achieve full and equal participation of all groups in a society that is mutually shaped to meet their needs. “Social justice includes a vision of society in which the distribution of resources is equitable and all members are physically and psychologically safe

and secure." (Bell, 1997, p. 3). Yet, according to Vera and Speight (2003), social justice has not received sufficient attention to integrate these principals into the clinical practice of mental health professionals. Several authors (Eriksen, 1999; Hage, 2003; Vera & Speight, 2003) argue that counsellors and psychotherapists can contribute to social justice issues through active involvement in advocacy, community outreach, and public policy making. While others suggest that helping professionals needs to be aware that power and its asymmetrical distribution can contribute to systemic, institutionalised discrimination (Gorski & Goodman, 2015). These contributions, from a social justice perspective, provide the basis for an expanded definition of multicultural competence.

Multicultural competence is generally defined as the extent to which counsellors and psychotherapists possess appropriate awareness (self-awareness and of the other), knowledge, and skills in working with individuals from diverse cultural backgrounds (Arredondo et al., 1996; Lago, 2010; Moodley & Lubin, 2008; Sodowsky, Taffe, Gutkin, & Wise, 1994; Sue, Arredondo, & McDavis, 1992; Sue, 2008). It has been proposed as a strategy to respond to diversity in contemporary societies and reduce mental health disparities. Initially intended for work with migrants and ethnic minorities, the multicultural competence model has also been adapted to include other forms of client diversity, such as age, gender, sexual orientation, gender identity, religion, social class, language, and ability status (Israel & Selvidge, 2003; Lago, 2016; Lago & Smith, 2010). This is in line with recent advances in the conceptualisation of culture in mental health research and practice as a process, in response to critiques of simple group-based definitions of culture stemming from social sciences and intersectionality approaches (Bowleg, 2008). In fact, the most recent revision of the DSM (DSM-5; Lewis-Fernández, Aggarwal, Hinton et al, 2016) recognises the importance of cultural case formulation and the understanding of culture as processual, rather than synonymous with a static group membership. Culture, hence, constitutes a process of

meaning-making that is under the influence of multiple, intersecting facets of a person's identity.

Demands for integrating multicultural perspectives into the profession have often resulted in resistance, mostly due to the belief that psychological laws and theories were universals and the invisibility of monoculturalism (Sue, 2001). Some authors have argued that, when dealing with individual and cultural differences, professionals need to take into consideration the sociopolitical ramifications of their work, including the impact on health inequalities (Hall, 2001; Lago, 2006; Sue, Arredondo, McDavis, 1992; Sue, 2008). Research has begun to explore the role of intersections of social categories, including socioeconomic status and its combination with individual and cultural minorities (e.g. Adler & Stewart, 2010; McGarrity, 2014). Results have suggested the importance of examining health inequalities in the context of socioeconomic status (SES). For example, among the Lesbian Gay Bisexual and Transgender (LGBT) population, findings support that there is much diversity in terms of SES and that the intersection of being LGBT and lower-SES represents a unique experience (such as exposure to more hostile environment to identity disclosure, stricter standards for gender conformity, more isolation from the mainstream LGBT community) resulting in greater psychological and physiological vulnerability to negative effects of discrimination (McGarrity, 2014). The search for mechanisms which may explain the processes by which socioeconomic status can affect health has also taken into consideration the environment. Factors such as differential access to quality health care, and differential exposure to stress (including stress resulting from oppression, discrimination, sexism, racism, and homophobia) have been explored (Adler & Stewart, 2010). While many questions remain unanswered in the exploration of racial health inequalities, there is a robust, graded association between socioeconomic status (SES) and health.

The purpose of the present paper is to contribute to the reflection on the impact of individual and cultural diversity on clinician-client interactions. Particularly, it aims to analyse individual and cultural diversity competences of clinical psychologists and psychotherapists in contemporary European societies and how these are put into practice in promoting equality of psychological care.

Method

Context and Design of the Studies

This study used an experimental design, in a qualitative analogue format, due to the limitations of self-report measures of cultural competence. The goal was to understand how psychologists and psychotherapists incorporate individual and cultural diversity factors in case conceptualisation, and how this can result in inequalities in psychological care. The positive and negative impacts of cultural characteristics in the therapeutic relationship and interventions with a possible minority client were analysed. Participants viewed two of the four videos of an acting client describing similar problems in an initial intake interview while varying in terms of ethnicity, religious identification and sexual orientation.

Participants

There were 31 participants in this study (26 women and 5 men) who were clinical psychologists and/or psychotherapists, with a mean age of 33.7 years (SD=5.44). Most did not identify as belonging to a minority group (n=14; 45%), but a significant part identified as such (n=12; 39%) and some did not respond (n=5; 16%). Among these clinicians, 32% (n=10) had basic training as a psychologist, 23% (n=7) held an additional master´s level course and 39% (n=12) post-graduate training in psychotherapy (in a psychotherapeutic society). Regarding clinical practice, participants reported a mean of 7.5 years (SD=3.75) of professional experience, ranging between 2 (Min.) and 15 years (Max.), with diverse theoretical trainings (CBT, humanistic, and psychodynamic as most common). Half the

participants in this study stated that they did not have any specific training in individual and cultural diversity (n=16; 52%), while the others (n=15; 48%) reported previous training on this subject (varying in length and content areas).

Instruments

Case vignettes/videos. The stimuli used in this study were four case vignettes, presented in the form of a video. Each video was approximately four minutes long and depicted a client in an initial intake interview, presenting with mixed anxiety and depressive symptoms and difficulties in academic adjustment as complaints (second year college student in sociology major, with adjustment issues after moving to a new city/country last year, away from family and social support, and experiencing decrease in academic achievement). Clients in the video were all female, young adults with no disabilities; hence, age, gender, education and ability status were controlled. However, clients represented stigmatised-group members varying in terms of migration background and ethnicity, religious background, and sexual orientation.

Interview protocol. The interview protocol was developed based on previous work by Neufeldt et al. (2006) and is presented in Table 1. Clinicians were asked open-ended questions after the video presentation concerning the following topics: 1) case conceptualisation; 2) possible intervention objectives and strategies; 3) identification of significant client characteristics; 4) identification of significant self/clinician characteristics; and 5) supervision needs. A final section addressed individual and cultural diversity directly; participants were asked how they integrated individual and cultural diversity in their psychological practice.

Insert Table 1

Procedure

For the construction of the case vignette videos, voluntary collaboration was asked of female psychology students aged 20 to 25 years old from four different countries (Portugal, Angola, Guinea and Brazil; all common immigrant groups in Lisbon), to perform as actresses. Case vignette stories were provided to the students, who developed their own text on video. Eight videos were taped and were rated in terms of credibility and attractiveness, by an independent team of researchers with experience on individual and cultural diversity studies. As a result of this evaluation, four of the eight videos were selected that best fit the goals of the study and matching "actresses" on credibility and attractiveness.

Participants were recruited through an earlier correlational study conducted by the authors, on the assessment of clinical individual and cultural diversity competences (in which over 200 psychologists and psychotherapists participated). In an online questionnaire, participants had been asked to leave their email contact in case they were interested in participating in future studies. From those who showed interest and agreed to future contact, 31participated in the present study. Confidentiality, anonymity, and voluntary participation were guaranteed.

Participants viewed two videos, presented in random order, each one followed by the interview questions (see Table 1). Videos were shown to participants on a laptop computer, in a university room prepared for this purpose. Previously, a list was made of all possible combinations of videos, to control for order effects. Each clinician was assigned a random video combination.

After watching each of the videos, interviews with participants regarding case conceptualisation were conducted. All individual interviews were recorded in audio format and transcribed by a research assistant. Transcriptions were analysed, in a blended model, incorporating features of thematic content analysis (Morant, 2006) and also Consensual

Qualitative Research (Hill et al., 1997; 2005), using NVivo software for data storage, coding, and theme development, where a team of researchers made decisions on the data by consensus.

Results

A total of 735 content units were analysed as answers to the questions to the vignettes. Frequencies of units of analysis by category (predefined as Blindness, Pre-competence, Competence, and Proficiency), following a developmental model of multicultural competences based the work by Fouad et al., 2009; and Trujillo, 2001, 2008, are presented in Table 2. Furthermore sub-categories (Openness to Differences/Attitude, Awareness, Knowledge, and Skills,) as identified in dimensional models of individual and cultural competence by Sue, 2008, or Israel and Selvidge, 2003, were defined. One unit of analysis was classified as discriminatory, namely, a negative remark / attitude of a participant toward LGBT clients when presented with the video of a lesbian client.

Insert Table 2

Results showed that awareness, knowledge and skills were identified mostly at a level of blindness and pre-competence, while only a few units of analysis were categorised as competent. Specifically, 519 (70.5%) content units were rated at the level of blindness, i.e. either not mentioning diversity issues at all in case conceptualization, objective setting and strategies, relational aspects of psychological care, and supervision needs, or explicitly referring that the perceived diversity would make no difference in such domains; *"In my work, I am indifferent to skin color"; "For me the religion of the client is not important"*. In this stage, positive aspects of the client most commonly identified by participants were her

motivation and help-seeking behavior (n=33), and her ability to express emotions (n=23). Challenging attributes were more frequently those related to symptomatology (n=19) and social isolation (n=12). Clinician strengths were commonly those referring to ability to empathise and similarly personal characteristics (n=43) and previous general professional experience (n=33). Challenging aspects related to clinician attributes mostly referred to cultural aspects, and hence were not coded as blindness. Only 23.5% (172) of the content of the text units was classified at a level of pre-competence. Participants recognised the existence of differences within the dyad (n=63); expressed respectful curiosity for the cultural experiences of the other and for exploring interpersonal differences in the therapeutic dyad (n=52), revealed some basic cultural knowledge on the specific stigmatised group (n=10); and included minimal clinical attention to individual and cultural issues in terms of making observations on client complaint and case conceptualisation, objective setting and possible strategies for treatment (n=47). Examples of statements of participants who recognised his/her own characteristics as possible challenges in the provision of psychological care for the client were:

> *… One difficulty could be the cultural aspects, such as religion… I am wondering, for instance, she spoke of her religion, Evangelical, and it is a religion I do not know anything about, but I would have to understand it, what her beliefs are, her rituals and practices, her faith* (Participant 27);

and “In terms of difficulties, I think I haven’t had much experience working with this group… I do not remember any case I have had of a Muslim client” (Participant 16). Finally, at the level of competence (n=43; 6.0% of units of analysis), some participants could recognise the client’s resources and strengths based on their ethnic, migration, or religious background. They stated; “There is also her faith which can help her; this faith or any faith can be explored and work as a resource of the client” (Participant 7); and “The client has

something positive. Even though she is having difficulties, she left her country of origin, her family, and she wanted to make it and took a chance. She is courageous" (Participant 3).

Nonetheless, overall, diversity in the clinical relationship was perceived more as a difficulty (58%) than a resource (35%). No statements were coded as being at the level of proficiency. Minimal attention was paid to social aspects related to educational level, social class or socioeconomic characteristics of the client, only as pertaining to the presenting complaint (decrease in academic achievement, adjustment to college).

Discussion

The present paper aimed to contribute to how psychologists and psychotherapists incorporate individual and cultural diversity factors in case conceptualisation and how this could result in inequalities in psychological care. It sought to do so through an analogue study, asking participants to demonstrate how they conceptualised diversity with particular cases presented in video vignettes, rather than using self-report measures of perceived competences sensitive to diversity. Our findings suggest that practitioners in our sample were mostly blind to individual and cultural diversity. In fact, a number of clinicians reported being open to diversity, but either seemed afraid to speak about the differences, or while addressing them, admitted they have had little experience and little training to work with diverse clients. These results are not surprising in the context of Portuguese society given the embryonic stage of training, research and practice in diversity-sensitive approaches in psychology, as consistent with previous research (Moleiro, Marques & Pacheco, 2011). While others (Celik, Abma, Klinge, & Widdershoven, 2012; Whealin & Ruzek, 2008) have reported such practices in training and their evaluation in some countries, these efforts are still few and unsystematic in Europe, despite the existence of international guidelines (e.g. Bhugra, Gupta, Bhui, et al., 2011; International Organization for Migration, 2009). This lack of training may contribute to health disparities in quality of psychological care, through micro-aggressions

and other forms of implicit bias, as found among physician-patient interactions (Hall et al., 2015; West & Schoenthaler, 2017).

Our study also revealed that culture seems to be far from being understood by clinicians as a process (Lewis-Fernández et al., 2016), in the intersection of multiple dimensions of client identities, and in dynamic construction of meaning in thetherapeutic relationship. In fact, while issues of religion and migration background were identified by some participants, other dimensions were more invisible (sexual orientation, social class and socioeconomic status) in case conceptualisation. This finding strengthens recognition of the need to integrate SES into research on health inequalities, and its interaction with other identity dimensions, as it may be an unexamined fundamental variable (McGarrity, 2014). In addition, White (heterosexual/lesbian, Christian) clients were rarely perceived as cultural. There were also difficulties among clinicians in perceiving themselves as cultural beings and exploring their impact on particular clients different from themselves in an array of identity dimensions, as already encountered by Neufeldt et al. (2006) and Haugh (2016). Finally, individual and cultural diversity in the clinical relationship was perceived more as a difficulty or barrier to psychological care than a resource or rich context for the exploration of meaning and coping strategies.

While we recognise the contributions of this study, we also acknowledge some limitations. First, it is relevant to recognise that the sample was relatively small. While adequate for a qualitative study, with rich and varied data to analyse, participants cannot be assumed to be representative of clinical psychologists and psychotherapists in Portugal or contemporary European societies. Furthermore, the sample was composed by volunteers, who were initially motivated and interested in issues related to individual and cultural diversity. Over one third of them identified as minority group members (in ethnic origin, religion, or sexual orientation) and indicated having had at least some exposure to individual and cultural

diversity issues during training, which may not represent the population of mental healthcare professionals. This warrants caution in both reading the present results, but also in the ability to generalise them. Even in a volunteer sample with minority group member professionals with initial training, results indicated that their ability to translate awareness and knowledge into competent practice was small.

Notwithstanding, this paper contributes to the discussion on individual and cultural competences among clinical psychologists and psychotherapists, and highlights the relevance of training, in contemporary European societies, given the current migratory context. Research on social inequalities in psychotherapy needs to be translated into policy; namely, training programs that assess interventions and their benefit not only on clinician competences, but also on end-users (clients) and their well-being (drop-out rates, treatment effectiveness, treatment satisfaction). Further research is needed on current training programs being offered and their impacts.

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Table 1 – Interview protocol

Exposure to First Vignette

Section I: Psychotherapeutic relationship and goals

1. What do you believe is this client's major problem or problems at this time?

2. If you feel more information about the client is needed, what else would you want to know?

3. What would be the therapeutic goals/objectives to work with this client?

Section II: Client's characteristics

4. What characteristics of the client might facilitate progress in this case?

5. What characteristics of the client might be challenging or problematic in this case?

Section III: Therapist's characteristics

7. What characteristics or experiences of yours, as the therapist, might facilitate progress in the work with this particular client?

8. What characteristics or experiences of yours, as the therapist, might be challenging in the work with this particular client?

9. Which issues would you be most likely to need discussing in supervision?

Exposure to Second Vignette

Sections I, II and III

Final questions

10. How much do you usually incorporate issues of diversity in your case conceptualizations?

11. While watching these 2 videos did you think to integrate diversity issues and how? If not, why not?

Table 2 – Frequencies of categories and sub-categories

	Units of Analysis (Freq.)
DISCRIMINATION	1
Attitude/Openness: Negative Attitudes	1
BLINDNESS	519
Attitude/Openness: No recognition of differences	224
Awareness: No awareness of self and other as cultural	93
Knowledge: Generalistic models	48
Clinical Skills: General clinical skills	154
PRE-COMPETENCE	172
Attitude/Openness: Recognition of differences	63
Awareness: Respectful curiosity for the cultural experiences of the other and for differences	52
Knowledge: Basic cultural knowledge	10
Clinical Skills: Minimal diagnostic and clinical attention to culture	47
COMPETENCE	43
Attitude/Openness: Recognition of differences	14
Awareness: Awareness of the self, other and culture	18
Knowledge: Knowledge of specific needs of cultural groups	5

Clinical Skills: Development of specific clinical skills	6
PROFICIENCY	0
Attitude/Openness: Recognition of differences	0
Awareness: Seeking continuous growth/awareness	0
Knowledge: Seeking to produce and disseminate new knowledge	0
Clinical Skills: Seeking to promote the development of new skills	0
Total	735