Cultural competency training in psychiatry

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Abstract

Recent reports indicate that the quality of care provided to immigrant and ethnic minority patients is not at the same level as that provided to majority group patients. Although the European Board of Medical Specialists recognizes awareness of cultural issues as a core component of the psychiatry specialization, few medical schools provide training in cultural issues. Cultural competence represents a comprehensive response to the mental health care needs of immigrant and ethnic minority patients. Cultural competence training involves the development of knowledge, skills, and attitudes that can improve the effectiveness of psychiatric treatment. Cognitive cultural competence involves awareness of the various ways in which culture, immigration status, and race impact psychosocial development, psychopathology, and therapeutic transactions. Technical cultural competence involves the application of cognitive cultural competence, and requires proficiency in intercultural communication, the capacity to develop a therapeutic relationship with a culturally different patient, and the ability to adapt diagnosis and treatment in response to cultural difference. Perhaps the greatest challenge in cultural competence training involves the development of attitudinal competence inasmuch as it requires exploration of cultural and racial preconceptions. Although research is in its infancy, there are increasing indications that cultural competence can improve key aspects of the psychiatric treatment of immigrant and minority group patients.

Keywords: Cultural competence; Immigration; Ethnic minority; Diversity training; Transcultural psychiatry

1. Introduction

The increased presence patients whose racial, cultural, national, or ethnic origin is distinct from that of the clinician represents a series of new challenges to the provision of quality mental health services. Competence to practice psychiatry is predicated on a series of skills, attitudes, and beliefs, which themselves are predicated on a combination of scientific knowledge and clinical experience. At the same time, comprehensive training in cultural and ethnic issues in psychiatry, although identified as a core component of the requirements for the specialization of psychiatry by the European Union of Medical Specialists [61] is rarely comprehensively addressed in medical training. The treatment of patients whose cultural, ethnic, racial, or national background is distinct from that of the clinician, then, is not based on the scientific training, but rather is left up to the devices of the clinician. What this suggests is that the quality of psychiatric services for culturally different patients may be wanting, precisely because of the lack of relevant training.

When confronted with a patient who is culturally different, the psychiatrist is generally faced with a dilemma: he or she must treat a patient but without the educational or scientific basis on which to do so. Although clinical experience is of considerable importance, unless it has a scientific basis it is of limited use, and is unlikely to meet the practice standards expected of physicians.

2. Professional competence in medicine

Professional competence in medicine is a complex combination of “technical, cognitive, and emotional aspects of practice” [29] which “builds on a foundation of basic skills, scientific knowledge, and moral development”. In addition to knowledge and technical skills, communication with the patient and establishing a therapeutic relationship are under-
stood to constitute key aspects of professional competence in medicine [29, 61]. Finally, consistent with the move towards values based medicine, professional competency includes affective and moral dimensions. Measurement of professional competence has proved to be a complex process, and all the more so with respect to more qualitative components such as values and self awareness [29]. Research does suggest, however, that communication skills are valued over technical skills by patients [17], and a strong case has been made that physician self-awareness can reduce errors in clinical practice [12].

The same combination of knowledge, skills, and attitudes comprise the foundation of cultural competence [55]. In the UK and the US the need for improving the quality of psychiatric care for ethnic minority and immigrant patients has been reasonably well established [11, 44], and “cultural competence” represents an approach in the provision of mental health services. Cultural competence, however, is not a unitary concept, but rather is a generic term that has no fixed definition.

The model of cultural competence presented in this paper is a synthesis of existing models combined with the authors’ clinical experience. As the bulk of research and theory on cultural competence and related issues in mental health has been carried out in the US, an attempt has been made to adapt North American models to the European context. The objective of this paper is to outline a cultural competence paradigm that can serve as a basis for the development of training and also be of use to practicing clinicians. The paper will begin with a detailed description of cultural competence, structured in the context of knowledge, skills, and attitudes. A discussion of the validity of the model will follow, as will specific training issues, and finally, suggestions for future directions for cultural competence training in Europe will be presented.

3. Cultural competence

It is generally accepted that cultural competence consists of institutional and clinical means of overcoming impediments to the effective provision of psychiatric services to immigrant and ethnic minority patients. Such impediments are complex and multifaceted, and as such cultural competence must be comprehensive in its response. To some extent, the use of the term “cultural” has confined two key aspects of the mental health care of immigrants and ethnic minority patients [34]. Cultural differences in the understanding, expression, and treatment of mental distress represent one key barrier to quality of care received by immigrants and ethnic minority patients. Racial difference can impede access to quality care due to provider and institutional bias. Poverty may be correlated with race, culture, or immigration, and act as a barrier to access to care. Cultural competence, then, must respond to all barriers to the provision of quality mental health care. This generic term is used to address a host of related but distinct socio-demographic factors. Immigration, culture, ethnic-minority status, religion, and race differentially impact mental health and its treatment.

Cultural competence training is by necessity practical, and as such consists of a basis of knowledge which the practitioner can than effectively apply to real-life clinical situations. Effective application of clinical knowledge in the context of cultural and racial difference and immigration further requires that the clinician is disposed to examine and challenge pre-conceived attitudes and beliefs that independently of the knowledge and skill base can impede effective practice. Limitations of time and resources mean that cultural competence training must focus on general principles that can improve the quality of care of all patients, rather than require knowledge and skills specific to each different cultural and racial group with whom a clinician may work [7,72].

3.1. Knowledge

The knowledge dimension of cultural competence is in large part predicated on concepts and terminology more proper to anthropology and sociology than to psychiatry and medicine. To that end, cultural competence training must begin with an overview and exploration of these terms and concepts. The complex relationship between the different terms and concepts (culture, immigration, race) and mental health, unless well elucidated can all to easily complicate treatment and diagnosis [32,64] by confounding issues related to culture, discrimination, and stress.

3.1.1. Cultural knowledge

Cultural competence involves the effective application of a specific knowledge base. Expediency demands that the knowledge basis is “transcultural”, that is, applicable across cultures. Knowing that there are different ways in which psychological distress is expressed and explained, for example, can reduce the probability of diagnostic error simply by virtue of clinician care. Knowing the specific ways in which a certain culture expresses or explains mental distress is problematic because of the considerable intracultural variability.

Generalizations are useful inasmuch as they remain as guidelines but do not convert into stereotypes that serve to obscure the individuality of the patient. Thus the knowledge domain of cultural competence is focused primarily on the ways in which culture, race, and immigration can impact psychosocial development, psychopathology, and therapeutic transactions. To that end, it is clear that cultural competence training must begin with an in-depth exploration of the key terms and concepts.

Cultural competence models are predicated on the idea that any clinician can, with the correct combination of knowledge, skills, and attitudes, effectively treat most every patient [72]. Comprehensive knowledge about the multitude of cultures that are represented by the many patients seen
over the course of a few months is virtually impossible to achieve given the variability and time constraints [7,55]. That which needs to be known about the culture in question constitutes a second problem with the idea of obtaining detailed cultural knowledge. Given that culture is “contested, temporal and emergent”, even within the same culture there are multiple perspectives; specific knowledge about a culture, runs a great risk reducing the complexity of the individual patient to a set of stereotypes [32].

Even were it possible to obtain comprehensive knowledge about multiple cultures, it remains questionable as to how to effectively apply this knowledge – an abstraction – to a specific client [63]. Knowledge is distal from the therapeutic interaction, and, indeed, it is at best a generalization, which has lead some commentators to suggest that culture tells us nothing about a patient or that cultural knowledge can be dangerous [32].

The knowledge necessary for effective intercultural work begins with awareness that psychosocial development, mental health and the treatment process are all intimately influenced by culture, immigration, and ethnic and racial difference. How they are related is, of course, highly complex, but warrant a detailed examination. In part, simple awareness of the relationship can be helpful as it thus orients the clinician to the possibility.

3.1.2. Culture

The complexity of the culture construct is such that in recent years anthropologists have begun to problematize the construct’s utility [13] precisely because it is questionable the degree to which any particular culture can be “captured”. Typically, culture is defined as “shared” in the context of values, norms, traditions, and so forth [34], and yet intracultural variability is such that reifications of culture runs a very clear danger of obscuring the relevant aspects of individual experience [32]. As Gregg and Saha note, culture “…is complex, problematic, and frequently contested” [34].

In the context of psychiatric practice, perhaps a more useful approach to culture is interpretive. The importance of the culture construct lies not in its predictive properties but rather in aiding understanding of how a person makes sense of their world. Such an approach avoids some of the pitfalls that occur with the more conventional definitions, in which the notion of culture, rather than serving to contextualize key aspects of the patient, creates distance – alterity – or acts as a catch-all explanation of all behaviors that may in fact be more related to social exclusion, poverty, or racism. Furthermore, such a definition is orientative. Key in this approach is the variability of subjective culture; in and of itself knowing a patient’s culture provides minimal a priori information about any specific patient, in large part because there are multiple ways any given individual lives her or his culture. Above all, this definition reminds practitioners that the importance of culture lies in interpretive and relational processes; how patient and psychiatrist make sense of each other, the presenting problem, the therapeutic process, and so forth.

3.1.3. Immigration

In many European countries, “immigration” has both a denotative (literal) as well as a connotative (evaluative) meaning. Immigration denotes living permanently in a second country, whereas the connotative meaning of immigration tends towards a problematic process that strains public resources and leads towards social problems. The former is relevant psychiatrically so as immigration can increase vulnerability to stress and thus psychopathology [8], whereas the second can only interfere in the development of the therapeutic relationship and communication with the patient. Many of the key aspects relevant to mental health and immigration are only distally related to culture and cultural issues. Although culture and cultural difference may be relevant, neither is necessarily a part of immigration stress.

3.1.4. Acculturative stress and integration

Ethnic minority status and/or immigration have been found to be only indirectly related to psychopathology. It is the stress involved in the migratory process that moderates mental health problems rather than the migration itself [8]. Acculturative stress, consistent with the stress-process model, is a function of the psychological, social, and economic resources available to a given individual. Immigration related stress is understood to consist of homesickness or cultural bereavement, acculturative stress, and perceived discrimination [65]. Immigration is a stressor precisely when the individual is unable to cope with the relevant demands.

Acculturative stress avoids some of the conceptual and empirical problems related to the notion of integration, which is generally posited as an optimal acculturation strategy [6]. Research suggests that integration is not necessarily positively correlated with mental health, as demonstrated by findings that more time spent in a country and host country language proficiency are sometimes correlated with increased levels of psychopathology [8]. Because integration of immigrants into the host culture remains a political objective, it may be the case that clinicians believe that their patients would be better off were they to integrate. Whereas acculturation is not a psychological concept per se, acculturative stress concerns a relevant psychosocial aspect of immigration, and thus represents a useful focus for cultural competence training.

3.1.5. Race and racism

Reports in both the UK [26] and the US [37,66] underscore the presence of racial and ethnic disparities in the provision of health care. These disparities are attributable not to cultural difference as such but rather to individual and insti-
tutional racism [59]. Race is a contested construct, with commentators disagreeing as to whether it is a social construct, a biological-genetic reality, or simply a non-existent category with the recent advances in genomics further complicating the debate [33]. Cultural competence training, then, must elaborate on these distinct claims, and describe both the genetic as well as the socio-political relevance of the construct.

In Anglo-American models of cultural competence, race as a social construct is readily embraced [28,44,59]. Race, it is argued, is relevant not because it has any inherent meaning, but rather because of the distribution of power and control over access to resources. The race construct is all the more contentious because its relevance derives from racism, and as such the implicit or explicit suggestion made by proponents of the construct is that many mental health professionals respond to their racially different patients in a biased manner. A solid body of research suggests that although racism may not cause psychopathology it constitutes an important stress factor that renders racial minority members more susceptible to health problems as well as mental health problems [10,50,70]. In addition, research also indicates that racial minority group members are diagnosed more frequently with psychotic disorders, have higher rates of involuntary hospitalization, and are more frequently subjected to coercive measures [2,41,49].

As a biological construct, race is of relevance due to the unproblematic use of Whites of European descent as the gold standard in the vast majority of clinical trials [48,67]. That genetic polymorphisms vary racially and may be responsible for the metabolism of psychopharmacological products is simply not taken into consideration in pharmacodynamics and pharmacokinetics research, and as such needs to be incorporated in treatment and dosage [43,47,58].

3.1.6. Ethnic and racial identity

Knowledge about a specific culture or racial group is of limited and indeed potentially problematic use in work with a specific patient, precisely because race and culture are political, social, and demographic attributes of a person, but are not psychological; in and of themselves they say nothing about any particular individual [16]. Racial identity has been proposed as a psychological response to an individual’s race related experience which demonstrates intra-group difference [2]. Models have been developed for both minority group members as well as majority group members, and the interaction of clinician and patient racial identity stages have been studied [35]. The general concept of racial/ethnic identity theory has received wide acceptance in the study of ethnicity, race, and mental health [2]. Racial identity has been correlated with mental health [16] and substance abuse [14], and has been shown to impact the therapeutic relationship [35]. Cultural competence training, then, would benefit from including a focus on Racial Identity Theory and its impact on mental health treatment [2].

3.1.7. Culture: idioms of distress and explanatory models

Training in the rudiments of medical anthropology can be useful for providing clinicians with a basic understanding of the complexity of the expression and explanation of psychological distress. Psychiatric diagnosis and treatment, for all the advances in medical science in the form of protocols, structured interviews, and treatment guidelines, are of questionable utility if, despite shared pathology symptom phenomenology and explanation are distinct. Culture influences the way in which symptoms are both expressed and understood. Thus the specific symptom clusters that are normative according to standard diagnostic criteria of the DSM-IV or ICD-10 are not universally expressive of a given mental disorder but rather reflect what is standard according to Western psychiatry. It is this very phenomenon that has been the impetus for efforts to develop more localized diagnostic criteria, as is the case with the Latin American Guide for Psychiatric Diagnosis [5] and the Chinese Classification of Mental Disorders [18].

The way in which suffering is expressed can vary considerably across cultures, to the extent that behavior that is typically symptomatic of psychosis according to Western nosology may be indicative of either another mental disorder or of nothing psychiatric whatsoever. Given that affective communication is culturally circumscribed, both “emotional lability” and “flat affect” are determined the degree to which the patient’s emotional expression departs from the culturally sanctioned norm. At the same time, clinical evaluation of affective expression is generally done as if the culturally sanctioned norm is applicable universally, the extent to which a normative expression can be interpreted as symptomatic. Behaviours and expressions often taken to be symptomatic of schizophrenia such as visual, auditory, and tactile hallucinations, for example, are often situational and in some Latin American populations better associated with anxiety and adaptive disorders [42]. Furthermore, some normative behaviour such as talking with deceased relatives or ancestors can also be viewed as symptomatic of psychotic disorders. Finally, there would appear to be a greater tendency to express mental distress somatically particularly in those cultures in which the mind/body dualism does not form a fundamental part of the dominant epistemology [38]. Somatic expression of distress is, of course, not unique to immigrant populations, nor is it the case that all immigrants somatize, but that distress not directly medical is often experienced and expressed through bodily experience. Some research indicates that care there is an approximately even distribution of patients who accept that their somatic complaints are psychogenic, of those who reject the notion and refuse mental health treatment, and those who reject the notion but accept the treatment [4].

At least four basic explanatory models have been identified: biological; psychological; social; and supernatural. Research consistently indicates that people of European ori-
gin, relative to people of non-European descent, are more inclined towards biological and psychological explanations, whereas people of non-European origin, relative to Europeans, are more inclined towards social and supernatural explanations [46].

Supernatural and social explanations of both schizophrenia and depression point broadly to fundamentally different understandings of the nature of human beings. Social explanations tend to pertain towards a loss of equilibrium over time, and these are often used to account for both affective and psychotic symptoms in many non-Western cultures. Such a perspective would appear to highlight the sociocentric or group centeredness, that contrasts with the more individualist focus found in the West [8]. Indeed, psychiatry’s tendency to explain psychological distress psychologically or biologically could also be said to reflect the cultural values common to a cultural system that prioritizes the importance of the individual.

Supernatural explanations range from the evil eye to spells and spiritual causes, and, although not unheard of in the West, form part of the epistemology of many non-Western cultures, to the extent that they are rather normal and could well be endorsed by the medical profession [9]. One of the dangers of the Western trained psychiatrist is succumbing to the belief that supernatural or biologically could also be said to reflect the cultural values common to a cultural system that prioritizes the importance of the individual.

3.1.8. Communication styles

Correct interpretation of the significance or meaning of what a patient communicates can be a considerable challenge in an intercultural context. Many communication styles are highly metaphoric [45] and indirect [68]; issues or themes are not stated directly but pointed to or suggested. Thus the culturally competent clinician will be aware of the metaphoric and indirect nature of communication and thus reduce the risk of taking the metaphor literally. Differences in communication style can impact the development of the psychiatric interview as well as the therapeutic relationship [51]. Although the communication itself requires technical and attitudinal competencies, training should provide knowledge about the communicative process as well.

3.1.9. Ethnopsychopharmacology

Ethnic variation in the response to pharmacological treatment has not been highly developed in the mental health literature. At the same time, a growing body of research indicates that pharmacological treatment is moderated by cultural and biological factors [43,58], which cultural competence training should address.

Pharmacological treatment does not simply involve pharmacodynamics and pharmacokinetics, but also the its meaning. Cultural mediates how treatment is viewed and what sort of meaning is ascribed to taking psychoactive medication. Because treatment adherence is often a concern [60], it can be useful for clinicians to be aware of the different possible reasons for non-compliance. Beliefs about illness and treatment can directly impact adherence. If a patient does not share the illness perspective held by the psychiatrist or if the patient is not convinced that the clinician has the best interests of the patient at heart, adherence may be compromised. In some cultures, notions of preventative medicine or relapse prevention, fundamental to Western biomedicine, are not shared, and thus patients may be inclined to adhere to treatment only while symptomatic. Clinicians may then adopt a less engaged attitude with patients who are perceived to be less inclined to continue treatment. In addition, negative medication beliefs are found to be more common in ethnic minority group patients than Whites. Fear of addiction and medication as symbolic of “crazy” are two examples of beliefs that will negatively impact adherence [31]. To that end, the importance of providing patients with good information about the illness and treatment cannot be underscored; many of the beliefs could be altered simply by educating the patient such that the treatment makes sense. Finally, research indicates that some ethnic minority groups prefer counseling or psychotherapy to medication. Problematic adherence is in part related to the clinician not finding a way to engage the patient in the psychiatric process, suggesting that it is precisely a lack of cultural competence that complicates the treatment process.

Genetic variations in different populations can influence the response to medications. The immigration process is at times involved, in as much as a change in diet can itself impact metabolization of certain medications. Basic awareness of these differences is key for dosage determination, although ethnopsychopharmacology remains a complex field, in part because none of the genetic variations are absolute, in part because of the limited research, and in part because the gold standard in randomized clinical trials (RCTs) of pharmacological agents continues to populations of European-American origin. What this suggests is that indicated dosage and indeed treatment may not be appropriate for certain population groups. For example, the probability of ultra-rapid metabolizers of antidepressants in the Arab population is higher than in the Continental European population, meaning that standard doses will rarely result in an adequate response [60]. This, combined with some of the cultural and social factors listed above – mistrust of the clinician, negative feelings about medication – can further complicate responsiveness to treatment.

3.1.10. Testing and research

The instruments used in psychological and psychiatric evaluation are generally developed and validated in Europe and North America with the “standard” patient who is of European origin and white [57]. To that end, many items are
biased in that they do not measure the same phenomena in the same way. Different ethnic groups may tend towards endorsing certain items in difference to other ethnic groups on a given test, suggesting that although the total score is the same the content is quite different [3]. Cultural competence training should provide an overview of test bias such that clinicians can understand how instruments used in mental health evaluation and research are biased.

Directly related to issues of testing are issues of research, particularly the RCT. Research on treatment, be it pharmacological or psychotherapeutic, tends to treat the intervention as universally applicable. Thus the many genetic, cultural, demographic and economic issues that could impact treatment outcome are rarely accommodated in RCTs [48]. Recent directives from the National Institutes of Health require that all research specifically address race and ethnicity, precisely because of the recognition that treatment efficacy, safety, tolerability or pharmacological agents has traditionally assumed the white male as the “norm”, and as such the findings may be of limited applicability with ethnic minority patients [67]. Thus there is an increase of research that focuses on the various minority groups in the US, but such research rarely addresses the ethnic minority groups present in Europe. In short, an important component of cultural competence training is culturally sensitive research [47].

3.2. Skills

The central issue with cultural competence skills training has to do with the difference between knowing that and knowing how [55]. Knowledge alone is not sufficient for cultural competence; cultural competence training involves the application of the knowledge base to both practice and research. It involves intercultural communication, the therapeutic relationship, the development of culturally appropriate interventions, and work with an intercultural mediator.

3.2.1. Intercultural communication

Communication forms the backbone of mental health treatment, to the extent that it is considered a core competence in medical and psychiatric practice [29,53,61]. Training in intercultural communication, then, must ensure proficiency in generic communication skills. Without communication, without understanding, arriving at an accurate diagnosis and effecting quality treatment is virtually impossible. Intercultural communication, even when the clinician and patient speak the same language, is complex due to the many differences that can exist in communication styles and non-verbal communication [62]. Cultural competence training will prepare clinicians to effectively communicate with patients from different cultures, that is, to apply the relevant knowledge to her or his interactions with the culturally different patient. Given that immigrant and ethnic minority patients may present explanatory models that differ considerably from those which the clinician is familiar, it is imperative that the psychiatrist has the capacity to truly “hear” or correctly interpret the patient. It is suggested, in fact, that clinicians be trained to develop flexibility in their communication styles to adapt to that of the patient [62, 68].

3.2.2. The therapeutic relationship

The therapeutic relationship is recognized as an optimal predictor of both adherence and outcome in psychiatry and psychotherapy [40,53]. Cultural and racial difference, however, can complicate the development of the therapeutic relationship [54]. The therapeutic relationship can be understood to consist of the bond between clinician and patient combined with the degree of perceived similarity regarding both treatment process and objectives. Clearly, different causal perspectives, notions about locus of control and social relations can have a direct impact on the therapeutic relationship. If the standard operative paradigm for the psychiatrist and patients are sufficiently distinct, the development of the therapeutic relationship will be compromised. Psychiatrist and patient may not be aware of differences in cultural values, and attribute the incompatibility of perspectives to individual (rudeness, lack of intelligence) motives.

Clinician bias and mistrust on the part of the patient can further complicate the therapeutic relationship [71]. Research from psychiatry specifically, and medicine in general, suggests that such bias has an influence of diagnosis and treatment. Although the clinician is unlikely to be aware of her or his implicit prejudices, the immigrant or ethnic minority patient may well be only too accustomed to racism and thus exercise considerable vigilance as a means of self-protection. For racial prejudice to not interfere with the development of the therapeutic relationship, a clinician must be conscious of her or his implicit racism and be inclined to reduce it. Regardless of the clinician’s prejudices or lack thereof, the patient may assume that the clinician, as a European, is racist. Clinicians can reduce the negative impact of this mistrust by comfortably addressing ethnic difference and racism to let the patient know that he or she can address the issue in the consulting room [39, 54].

3.2.3. Flexible interventions and treatment planning

Treatment planning and goals, as well as the specific interventions, used are predicated on the epistemic foundation the underlies the treatment model employed. In the biomedical model, treatments target symptom reduction or management in the short term, with disorder remission as a longer term goal. As treatments are increasingly specialized it is the symptom that is treated to the exclusion of broader, contextual concerns of a person’s life [52]. Given that for many immigrants and ethnic minority patients it is precisely the contextual issue related to immigration that play a significant role in the mental distress, effective treatment requires inclusion of these contextual issues. The treatment plan and
interventions should be coherent and meaningful for the patient and be responsive to their needs. At the same time the clinician must maintain her or his integrity as a mental health professional; flexibility has its limits.

As previously noted, the therapeutic relationship is comprised by the bond as well as the agreement as to the tasks and goals of the treatment. Achieving a positive therapeutic alliance, then, is in part related to therapeutic tasks and goals. Agreement on tasks and goals can best be accomplished by negotiation; rigid adherence to standardized or received practice does not necessarily serve therapeutic outcome. In many cases, patients simply do not have a clear notion of therapeutic transactions, and thus simply informing about the treatment process can be useful.

3.2.4. Working with an intercultural mediator

Whatever degree of cultural competence attained, there may be patients with whom an intercultural mediator will be needed. Clearly, this will be the case with those clients with whom communication is compromised due to language differences, but cultural differences may also impede the communication and the development of the therapeutic relationship. The presence of the intercultural mediator can serve to increase the level of confidence and comfort of both the clinician and the patient [19]. Knowing that the mediator is present assures both participants that they will be able to understand each other. In addition, it lets the patient know that an extra effort is made on his or her behalf, which in turn can increase her or his trust in the therapeutic process. At the same time, the presence of a third person in the treatment process can be challenging for the clinician, and to fully take advantage of this presence requires some adaptations.

Cultural competence training need be extended to included the effective use of an intercultural mediator. Some aspects that can improve the quality of the triadic interview include a pre-session meeting in which the objective of the session is explained and specific taboos and strategies discussed, and the clinician should always speak directly to the patient in order to facilitate the development of the therapeutic relationship [56].

3.3. Attitudes and beliefs

Effective application of cultural knowledge is key to clinical cultural competence. This requires a third essential component, which is the attitudinal competence that is the basis of effectively managing some of the more emotional aspects of intercultural work. Research consistently demonstrates that a significant proportion of “health disparities” that is, unequal health care interventions, can be attributed primarily to prejudice and racism. The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists [1] published by the American Psychological Association in 2003 summarize this point well in Guideline 1.

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 (p. 82).

This is perhaps the most challenging of the competencies, precisely because it demands examination and exploration of attitudes and beliefs that may not be particularly comfortable. The sort of detailed examination into one’s racial and cultural heritage, attitudes and beliefs about race, culture, and immigration required by this competency may demand confrontation with socially and ideologically undesired attitudes. For majority group members, this involves exploration of the privilege that accrues simply by virtue of belonging to the majority group, privileges that are a function of individual and institutional racism. The biggest challenge of this competency is not the complexity of the material but of the capacity to identify and correct racist and ethnocentric attitudes and beliefs.

Training in this competency domain can be challenging, and requires considerable sensitivity and expertise to avoid what is sometimes cynically referred to as “political correctness training”. Trainers must create an open and safe environment in which participants will feel sufficiently comfortable to explore sometimes difficult and painful ideas and emotions concerning such sensitive issues as race and immigration [15]. That participants (and their trainers as well) have prejudices that can compromise their intercultural work is taken as a given, and it is precisely the recognition of these prejudices that marks the important first step. Subsequently, the prejudices should be problematized and efforts made to develop more professionally appropriate perspectives.

3.3.1. Cultural humility

A potential danger in competency models is the notion that mastery is possible, such that one can indeed be an culturally competent clinician. This has led some observers to call for caution in order to avoid the sort of over-confident or arrogant stance that can impede effective care [64]. Cultural humility serves as an antidote and reminds clinicians that intercultural work is complex, and that cultural competency is an ideal that is unlikely to every, fully be reached. Rather what is key is the awareness of the limitations of absolute knowing in intercultural work.

4. Training issues

Ideally, cultural competence would be included as a core competence for medical practice, and thus be required for accreditation of medical schools, and be included on licensing exams. One of the central issues, however, pertains to the specific training model. Different possibilities include the integration of cultural and racial issues into all aspects of training,
specific courses, training rotations, or workshops. Accreditation by the American Psychological Association requires doctoral programs in clinical, counseling, and school psychology (required for eligibility to sit for the psychologist licensing exam) to provide training in diversity issues [20]; the evaluation of doctoral programs in clinical, counseling, and school psychology requires that cultural diversity issues are incorporated in all aspects of the training program, including faculty members and student body. The American Psychiatric Association’s Council on minority mental health and health disparities advocates for cultural competence training in medical training and faculty development [59]. In the UK, the Ethnic Issues Project Group of the Royal College of Psychiatrists in their Council Report of 2001 stipulated that all psychiatrists must be competent to provide diagnosis and treatment to all patients regardless of ethnic and cultural background. In addition, an objective was the inclusion of cultural diversity questions in the licensing exam [30]. At the same time, however, although diversity issues are addressed in a significant proportion of medical schools, the overall approach is deemed to be “fragmented” as there is minimal consensus as to what should be taught and how [27].

The teaching of cultural competence has been criticized for being simplistic and one-dimensional, to the extent that the training can provide clinicians with a false sense of expertise that in turn can result in stereotyping and thus a poorer quality of care [34,64]. To that end, whatever format used – undergraduate training, faculty development, continuing education – training must ensure that the full complexity of the relevant issues are addressed and that the trainees become proficient in cultural humility if nothing else [36,64].

Because cultural competence is multidimensional, training must be comprehensive and multimodal in order to respond to the different competency domains. Optimal training will attend to cognitive, technical, and attitudinal competencies, each of which is best served by distinct educational approaches. As to whether cultural competence training should be incorporated into all aspects of training, be covered in individual coursework, or in continuing education will depend on institutional and individual criteria. It would appear, however, that experiential approaches best serve the attitudinal domain [15], and in particular issues relating to race and racism. Although the single-course model is perhaps the most logistically feasible, it runs the risk of isolating “cultural issues” as if they are additional considerations that are of minimal relevance; as this review indicates, race, culture, and immigration can impact most every aspect of psychiatric practice.

5. Evaluation of cultural competence

A criticism of cultural competence is that it is too abstract and general and does not provide clinicians with specific tools and skills [25,69], a criticism that can explain why research into the specific impact of cultural competence training in psychiatry is limited [11,28]. Evaluation of the more process related components of competence is elusive [29]. Utilization of self-report is subject to social desirability [24], and in effect merely indicates the degree to which a research participant claims to endorse test items consistent with theorized cultural competence. Evaluation requires that cultural competence be practically operationalized. The use of case-conceptualization would appear to show some promise, and research indicates that cultural competence is correlated with the therapeutic relationship and patient satisfaction [21-23]. At the same time more research is required.

6. Conclusions

Cultural competence represents a comprehensive response to the mental health needs of immigrant and ethnic minority patients. The barriers to effective mental health treatment are both organization and clinical, and thus require that adaptations at both of these levels. Organizationally, it is imperative that mental health centers take steps to ensure that language does not impede both service access as well as provision. In addition, access is served by taking steps to adapt services to the specific needs of patients, which may mean extending hours of operation and creating an environment that increases comfort.

Clinical cultural competence is comprised of knowledge and skills that respond to the cultural and immigration related aspects of mental health and communication. Awareness of the many ways in which culture can impact the expression and understanding of suffering and mental distress and the relevant diagnostic and treatment adaptations are key aspects of cultural competence. In addition, the capacity to effectively communicate and develop a positive therapeutic relationship are essential for the provision of quality mental health services. Finally, accommodation and management of bias, both on the part of the mental health professional and the patient is perhaps the most difficult of the cultural competencies, precisely in as much as this involves attitudinal competencies, which are generally more difficult to develop than the acquisition of knowledge and skills.

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