Cultural and Individual Diversity in Mental Health Services – Defining and assessing clinical competences

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Abstract

One of the most significant challenges facing the provision of health care in present societies is the fact that it needs to be sensitive to the growing diversity of patients, their families and origins. This is particularly salient in mental health care given the fact that most models of etiology and treatment were not historically-rooted in such diversity. The present paper describes the work that our team has been developing in order to (i) provide culturally and individually diverse groups in Portugal an opportunity to voice their psychological health needs, experiences and expectations of sensitive health services; (ii) develop distinct methods for assessing individual and cultural diversity competences for mental health practitioners; and (iii) ultimately lead to the discussion and greater recognition of such specific competences. Thus, this paper will present a description of our project and the five studies that were developed (both with clinicians and clients/potential clients). Key findings are included, followed by a brief conclusion and implications for practice.

Keywords: Intercultural sensitivity; Mental health; Minority clients; Patient-centred care; Individual and Cultural Diversity.

"Social issues such as stereotyping, institutionalized racism, and dominant-group privilege are as real in the examining room as they are in society at large."

(American Institutes for Research, 2002, p.8)

One of the most significant challenges facing the provision of health care in present societies is the fact that "*culturally diverse groups comprise the largest growing segment of the patient population*" (Anand & Lahiri, 2009, p. 387). As such, health practitioners face increasing diversity in health explanatory models, beliefs, values and practices, cultures, and even linguistic backgrounds of their patients, as well as greater variety in epidemiology and disorder manifestations. Practitioners need to recognize distinct expressions of distress and become aware of more stress-sensitive etiology in terms of mental health. This recognition has led to the development of diverse guidelines of professional organizations (e.g. APA, 2003, 2012), focusing on the health professional (Daniel, Roysircar, Abeles, & Boyd, 2004).

In fact, mental health is of particular relevance given that certain conditions surrounding minority stress (gender; sexual orientation; e.g. Meyer, 2003) and migration processes (e.g. Bhugra et al., 2011) may increase vulnerability and minority groups may be exposed to a higher number of risk factors for psychological distress (e.g. related perceived discrimination, social exclusion, stigmatization and victimization, cultural and language differences, legal status, access to health services). Recent literature has emphasized the role of not only explicit discrimination, but also of implicit attitudes in interpersonal interactions (evaluations automatically activated by the actual or symbolic presence of a social object; Dovidio Kawakami, & Gaertner, 2002; Hebl, Foster, Mannix, & Dovidio, 2002; Kawakami, Phillis, Steele, & Dovidio, 2007) and micro-aggressions in daily life (continuous experiences of

aggression, often invisible to the perpetrator, who unconsciously holds biases and prejudice; Constantine, 2007; Sheldon & Delgado-Romero, 2011; Sue, 2010). These may have significantly more and stronger effects on well-being.

In spite the recognition of the need for culturally competent mental health services, health and mental health care disparities have been largely documented, both in the USA and in Europe (e.g. the 2008 Report of the World Health Organization's Commission on Social Determinants of Public Health; or the 2001 Report of the Surgeon General on mental health, culture, race and ethnicity by the US Department of Health and Human Services). The sources of disparities in healthcare 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). The International Organization for Migration (IOM, 2009), for example, concluded "*the prevalent health care model, under which the workers deliver services, has, in many countries, failed to guarantee fair, equitable and culturally appropriate health care for everyone (…). An important and urgent task is to transform the model so that it is better adapted to the real needs of a culturally diverse society. Such a transformation, however, cannot take place without health professionals who support the required changes and deliver culturally appropriate, equitable and competent care*" (p. 8). Furthermore, mental health practitioners are people and, as pointed out by the American Institutes for Research (2002), are also likely to hold biases, and the issues of stereotyping and discrimination may be as real in the clinician-patient relationship as in any other interpersonal relationship. There is, in fact, evidence of stereotyping and bias among healthcare providers (e.g. Bieschke, Paul & Blasko, 2006; Moleiro, Silva, Rodrigues, & Borges, 2009; Van Ryn & Burke, 2000).

The western biomedical health model has created a professional culture, based on specific values (e.g. power, agency, objectivity, spiritual skepticism, heteronormativity, ablebodiness), which may differ from the diverse cultures of those attending health services. In other words, the healthcare system itself can be less in accordance with cultural perspectives of some patients than others. Nonetheless, a more efficient, effective and client-centred health care will improve its quality for all (i.e., the total population and not just members of ethnic or other minority groups).

Individual and Cultural Diversity (ICD) Competence

Originally conceptualized as cultural sensitivity or responsiveness, definitions and perspectives on the meaning of cultural competence vary. The foundations of multicultural counselling were laid down by Sue, Arredondo and McDavis (1992), who presented a tri-dimensional model which posited the central role of (i) clinician awareness of own values and biases, and the patient's worldview; (ii) knowledge and (iii) skills of culturally-sensitive intervention strategies (Arredondo et al., 1996).

The first dimension – awareness – refers to the way the helper's attitudes, beliefs, values, assumptions, and self-awareness affect how they interact with those patients who are culturally different from themselves. It involves the exploration of the self as a cultural being, and of one's own cultural preconceptions. The second dimension – knowledge – relates to the informed understanding of cultures that are different from one's culture, including their histories, traditions, values, practices, and so forth. It also involves knowledge about such concepts and processes as cultural impacts on psychosocial development, acculturation models and acculturation stress, ethnic and racial identity development, cultural communication styles in the helping relationship, perceived discrimination as a risk factor for well-being, and culture-bound

syndromes and culture-specific interventions. Finally, an important third dimension consists in the ability to engage in effective and meaningful interactions with diverse individuals, including the development of a relationship, by integrating one's awareness and knowledge into practical skills in the helping relation, assessment and intervention (Arredondo et al., 1996¸ Pope-Davis, Coleman, Liu, & Toporek, 2003).

Israel and Selvidge (2003) built upon these foundations in order to conceptualize clinical competence with Lesbian, Gay, Bisexual and Transgender (LGBT) persons, building a broader vision of clinician individual and cultural diversity competence. In fact, the growing empirical and clinical literature on LGBT issues has been mostly invisible in mainstream psychology (Goldfried, 2001). Moreover, recent reports still evidence that there are therapies (and therapists) aimed toward changing the sexual orientation of non-heterosexual patients, even though they are widely questioned, both ethically and scientifically (APA, 2009). Moreover, there is evidence of other forms of inappropriate (while less blatant) clinical practices with LGBT patients (e.g. Gelso & Mohr, 2001). Even those clinicians who intend to be affirmative and supportive of LGBT individuals can reveal subtle heterosexist bias in the work with these patients (Pachankis & Goldfried, 2004), thus the importance of extending cultural and ethnic diversity competence to ICD competence.

Taken globally, all perspectives on ICD competences imply that practitioners in clinical settings (namely, mental health services) are able to demonstrate their ability to perform adequate and quality care to culturally diverse patients. As such, it has been defined as a dynamic and complex process of being aware of and recognizing individual and cultural differences, which are reflected in a practitioner's attitudes and beliefs, knowledge, and skills in working with

individuals from a variety of cultural groups (e.g. racial, ethnic, religious, gender, social class, sexual orientation, disability; Constantine & Ladany, 2001; Daniel et al, 2004).

In interdisciplinary literature (Spitzberg & Changnon, 2009), a number of models and frameworks have been proposed for understanding "intercultural competence" (which we refer to as ICD competence). Our own research has approached this within a compositional and developmental framework with three main working dimensions, without neglecting its adaptation and interactive nature. Developmental models explicitly recognize that intercultural competence develops over time, postulating stages of its development (e.g. Cross et al., 1989; Trujillo, 2001).

Brief Project Description

In the last five years, our team has been conducting a study in Portugal, regarding ICD competences among mental health professionals. The project was entitled "Mental Health, Diversity and Multiculturalism: Toward the integration of specific needs of minority groups and Professional multicultural competencies" (ref. PDCT/PSI/71893/2006). The objectives of this project were two-fold. Firstly, it aimed to explore the representations of mental health and illness held by minority groups in Portugal, identifying their main concerns associated with the use of mental health services, and characterizing their specific needs within the interactions with mental health professionals. Secondly, the project proposed to examine ICD competences of psychologists working with minority group clients in Portugal, identifying these competencies, creating two specific instruments for their assessment, and surveying and exploring the way these competences are put into practice.

In order to reach the first goal, a qualitative study (Study 1) was developed with a sample of 40 adults from different ethnic minority groups in Portugal – a total of 30 women and ten men

– with a mean age of 34. Participants took part in one of eight focus groups, which were conducted using a semi-structured interview plan (Moleiro, Freire & Tomsic, 2013). Similar focus groups were conducted with LGB clients (Study 2; see Moleiro & Pinto, 2012).

With regard to the assessment of clinical ICD competences, the project included two components. In the first one, we developed a brief self-report instrument directed toward mental health professionals. After a small pilot study (Study 3), over 300 clinicians responded to the online self-report questionnaire (Study 4), of both sexes (female=87%), different ages (mean=32; 21 to 64 years old), theoretical training models (almost half cognitive-behavioral) and years of clinical practice (mean=7; range 0-28 years). In the second component (Study 5), and in order to reduce the limitations of self-report instruments, we conducted an analogue study by having psychologists (N=31) watch video case vignettes with a minority client followed by a semi-structured interview. The study used an experimental design and aimed to assess ICD competences of clinicians through their case conceptualization, exploration of the therapeutic relationship, and intervention planning. Two cases (out of four videos) were presented to each psychotherapist (chosen at random, and controlling for order of presentation), and interviews were conducted regarding each of the clients. The interview ended with a set of questions regarding how they thought they integrated ICD into their own clinical practice.

In both sets of studies, transcripts of the interviews were analyzed, in a blended model, incorporating features of thematic content analysis (see Morant, 2006) and also Consensual Qualitative Research (Hill et al, 1997; 2005).

Key Findings

Our research showed that, generally, ethnic minority clients (Study 1 - Moleiro, et al, 2009; Moleiro, Freire & Tomsic, 2013) and LGB clients (Study 2 - Moleiro & Pinto, 2012) had

experienced discrimination in the healthcare system, and that mental healthcare was perceived as mixed (both positive and negative). Furthermore, participants identified specific aspects of culturally sensitive treatments, providing support for the tridimensional model of multicultural competencies. These included awareness (e.g. "when dealing with patients who are from different races and ethnic groups, they have to be aware of the patient's culture, his/her habits, and religious practices"), knowledge (e.g. be "knowledgeable about the origin of the person in order to find out more about where she comes from, her way of life.") and skills (e.g. "help overcome language difficulties"). These findings are consistent with the work of others (Cook, Kosoko-Lasaki, & O'Brien, 2005).

The final survey (Study 4) revealed that 84% of clinicians reported having had no specific training on diversity issues. Yet, 48% of them indicated experiencing some to moderate difficulties when working with minority group clients and 96% indicated that receiving further training on ICD would be useful. In fact, only 27% indicated having no minority clients in their practice. On this self-report measure, most clinicians indicated having average to good ICD competence (mean=3.86, on a scale 1-5). Statistically significant differences were found between participants with and without specific training - for the total score and all dimensions except "Openness", with higher values for clinicians with training. There was also a significant correlation of perceived ICD competence and years of professional experience ($r=.22$, $p<0.01$).

In contrast, data on ICD competence in response to case vignettes (Study 5) revealed a less positive scenario. In effect, self-report and demonstrated competence have shown weak associations (Moleiro, Marques & Pacheco, 2011). 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 categorized as competent (see Table 1). Diversity in the clinical

relationship was still perceived more as a difficulty (58%) than a resource (35%). While a number of clinicians reported being open to diversity, they seemed afraid to speak about the differences in the helping relationship. Finally, as shown by Neufeldt et al (2006), White (heterosexual, Christian) clients were rarely perceived as cultural – it is as if "Whiteness" was the norm and the "Other" was *exotic* or *different*; and there were also difficulties among the clinicians to perceive themselves as cultural beings and exploring the impact that they (themselves) have on the clinical interaction.

Conclusion and Implication for practice

Psychological work with people and groups culturally and individually diverse represents a challenge for both practitioners and clients, mostly when needs are not met and barriers not overcome. This work implies not only the promotion of the awareness of the existing differences, barriers and difficulties, but also the knowledge and respect to those specific characteristics and needs. It seems, therefore, necessary to develop specific competences for the sensitive integration of the clients' cultural and individual diversity into explanatory models of distress and suffering, as well as intervention.

Accordingly, our research has highlighted the importance of ICD competence training for clinicians, both from the (potential) client and professional's point of view. While others (Celik, Abma, Klinge, & Widdershoven, 2012; Whealin & Ruzek, 2008) have reported such practices and their evaluation in some countries, these efforts are still few and unsystematic in Europe. This research also supports that self-report measures of clinical cultural competence are limited when assessing clinicians with openness to cultural issues, but little awareness and knowledge. Thus, the development of effective forms of assessing ICD competence is also of a great importance.

Therefore, some important gaps are to be recognized. For the past few decades, international literature has been intensively working to demonstrate the importance and impact that the development of ICD competence could have in clinical practice; however, in our view, steps toward their application and assessment in daily practice have been scarce. Hence, there might be a great distance between the specific needs of some clients and the mental health care currently provided [or yet the care that *could* be provided]. These gaps may be, not only hindering the development of mental health professional competences to work with diverse people, but most importantly failing to provide sensitive and effective care to those seeking psychological help.

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Table 1: Frequency of Units of Analysis from transcripts of interviews to mental health professionals regarding minority clients

Level 1. DISCRIMINATION	**Frequency UA**
Belief: Presence of differences – superiority	0
Attitude & Awareness: Discriminatory attitudes	1
Knowledge: Generalistic models	0
Clinical Skills: General clinical skills	0
Total	**1**
Level 2. BLINDNESS	
Belief: No recognition of differences	224
Attitude & Awareness: No awareness of self and other as cultural	93
Knowledge: Generalistic models	48
Clinical Skills: General clinical skills	154
Total	**519**
Level 3. PRE-COMPETENCE	
Belief: Recognition of differences	63
Attitude & 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 cultural issues	47
Total	**172**
Level 4. COMPETENCE	
Belief: Recognition of differences	14
Attitude & Awareness: Awareness of the self, the other and of cultural issues	18
Knowledge: Knowledge of specific needs of particular cultural groups	5
Clinical Skills: Development of specific clinical skills	6
Total	**43**
Level 5. PROFICIENCY	
Belief: Recognition of differences	0
Attitude & Awareness: Seeking to continuously grow and expand awareness	0
Knowledge: Seeking to produce and disseminate new knowledge	0
Clinical Skills: Seeking to promote the development of new skills	0
Total	**0**