

## THE AMERICAN MODEL OF PSYCHOTHERAPEUTIC CULTURAL COMPETENCE AND ITS APPLICABILITY IN THE SPANISH CONTEXT

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*The increasing presence of culturally different clients in Spanish mental health services constitutes an important challenge for the effective delivery of care. Cultural competence has been proposed as a general approach for improving services, which requires changes at both institutional and clinical levels. The vast majority of cultural competence models have been developed in the United States. Clinical cultural competence consists of specific knowledge, skills, and attitudes that function together to provide an individualized, culturally sensitive and appropriate treatment. Despite a highly promising start, cultural competence in mental health needs to be further defined, adapted, and researched for effective application in the Spanish context.*

**Key words:** cultural competence; cross-cultural psychiatry; psychotherapy.

*La progresiva presencia de usuarios culturalmente diferentes en los servicios de salud mental constituye un reto importante para la calidad asistencial. Se ha propuesto la competencia cultural como un enfoque general para mejorar estos servicios, lo que implica cambios tanto a nivel institucional como clínico. La gran mayoría de los modelos de competencia cultural se han desarrollado en los Estados Unidos. La competencia cultural clínica consiste en la adquisición de unos conocimientos específicos, unas habilidades y unas actitudes con los que poder ofrecer un tratamiento adecuado, individualizado y culturalmente sensible. Pese a disfrutar de un esperanzador comienzo, la competencia cultural en salud mental necesita hoy en día un mayor impulso que permita su correcta definición y adaptación de cara a su efectiva aplicación en el contexto español.*

**Palabras clave:** Competencia cultural; psiquiatría transcultural; inmigración, psicoterapia.

Setting an objective such as establishing best practice through formalized standards and competencies is typical of North American pragmatism. Guidelines and competencies for working with persons from other cultures and races have been, or are being developed in almost all areas of social and healthcare services. The models usually deal with competence at the structural, institutional and clinical levels. In medicine, more attention has been paid to structural and institutional levels, while in psychology the focus has been on the clinical level. Although here we shall also pay more attention to the clinical level, structural and institutional commitment to cultural and racial diversity is indispensable.

Clearly, the North American model is not wholly applicable to a multicultural context as different as that of Spain. Nevertheless, the former has more than 30

years of valuable experience in this field, covering multicultural work in psychology, medicine, nursing, etc., and promoting working groups and professional journals such as the Association of Non-White Concerns, the Journal of Black Psychology or the Multicultural Counseling Association. It should be stressed that work in this area did not begin with the arrival in the United States of populations from other cultures and races (these were already present almost from the country's beginnings), but rather with the entry of numerous professionals from ethnic minorities into hospitals, universities and professional associations.

### DEFINITIONS

The North American literature acknowledges that there are serious problems with the provision of social and health services to persons from different ethnic groups. Problems include not only those of nomenclature, but also those related to basic concepts which require clarification before we begin, to ensure that we are talking about the same thing.

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### **Culture**

The definition of culture we often use sees it as a series of artifacts, customs, rituals, foods, values, habits, etc., which are essentially products and activities. While adequate as a heuristic, it has some serious limitations when applied to intercultural work. Culture viewed in this way is something fixed in time and space, something which can be known, had and lost. Cultural competence requires a different understanding, which we shall look at shortly.

Another perspective sees culture as a process and a context. According to Jenkins (1996), culture is:

*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 (p. 74).*

In the context of social and health care services, the importance of culture is linked to interpretation. The culture conditions the interpretation of the situation (the illness or problem and its cause, the care relationship, the way the problem is solved) by the client and the professional.

### **Race**

Race is a concept that defines the North American reality, yet the existence of which is denied in continental Europe. Since the model presented here is North American, it would be useful to define it as it is understood within the social sciences there, in the United States.

Hardly anyone views race as a biological phenomenon; race is understood as a social construct used to control access to resources. Janet Helms, one of the pioneers of multicultural counseling, uses the term "socio-race" to emphasize the socio-political aspect of the concept. The basis of the difference is arbitrary – whether by skin color, place of origin, religion or ethnic origin. According to Martínez and Carreras (1998), racism is:

*an ideological social construct, sustained by a wide range of outside interests, superimposed on the strictly*

*scientific ones, and conditioned by a specific model of international economic and political relationships that conferred, and still confers, on its advocates some type of benefit through its maintenance and persistence (p. 62).*

Racism is a power relationship, and to speak of race therefore implies the recognition of an imbalance of power between different groups.

### **Immigrant**

The United States and Canada are countries made up largely of immigrants and their families. Any person who moves to another country to start a new life is an immigrant, not only those who seek to improve their economic circumstances. The stress factors linked to immigration (the change of culture, leaving one's homeland, feeling different from others, perceived discrimination) can affect any immigrant, though the more resources one has, the easier it is to deal with these stressors. Within the model of cultural competencies, an immigrant is a person who comes from another country to start a new life.

### **Ethnic group**

Ethnic group refers to a more specific group of shared characteristics, distinct from culture, which can relate to a subgroup within a particular culture – for example the Inuits in Canada, or a group which is present in different cultures, such as the Kurds in Turkey, Iraq and elsewhere. According to Helms and Cook (1999), ethnicity can be understood as "the national, regional or tribal origins of one of the oldest remembered ancestors, and the customs, traditions and rituals handed down by such ancestors ..." (p.19).

### **Identity**

Within the general context of multicultural societies, identity is playing an increasingly important role. Cultural, racial or ethnic origins can affect individuals in two important ways. The first, and most basic, is in the context of culture: this determines the system of meanings through which the individual makes sense of the world. The second is in the context of identity, or how one sees oneself. Identity refers by definition to constancy over time, and one's racial or ethnic identity is an important part of this process. Research has indicated for example, that ethnic or racial identification moderates drug consumption. (Brook, 1998; Brook, Whiteman, Balka, Win, and Gursen, 1998; Marsiglia, Kulis, and Hecht, 2001).



The greater one's sense of ethnic identity, the less likely drug abuse becomes.

The academic world is increasingly valuing the notion of ethnic or racial identity as extending beyond a simple zero sum equation (one identifies oneself or not with a group in question), and arriving at a definition that considers identity as a process (Helms and Cook, 1999; Phinney, 1990), directly related to resistance skills, vulnerability and mental health. The general idea is that there are many ways to identify oneself with the group, and that the pertinent variables include the degree of identification, the way one identifies oneself, and the way in which one negotiates identity between one's ethnic or racial group and the culturally dominant group. As will be seen, the cultural competence model requires social and health care service personnel to be up to speed on the different models of identity.

The most accepted models start out with the notion that racial or minority/majority identity of a group is fundamentally dialectic. The way in which one relates oneself to one's group is inseparable from how one relates to the "other" group (Carter, 1995; Helms and Cook, 1999). As mentioned above, race implies a power relationship, and it is this relationship which is omnipresent in racial identity.

### MEDICAL MODELS OF CULTURAL COMPETENCE

There is, of course, a great variety of medical models of cultural competence, and we cannot attempt a thorough presentation here of each one. Nevertheless, the models tend to share certain basic components. In particular, they tend to place considerable emphasis on institutional and structural competencies (Betancourt, Green, Carrillo, and Ananeh-Frempong, 2003; Health Resources and Services Administration US Department of Health and Human Services, 2001). Competence is essentially defined as the medium for breaking down the barriers that impede access to public health services.

#### Institutional competence

The second item of the National Standards on Culturally and Linguistically Appropriate Services (CLAS) (Office of Minority Health, Department of Health and Human Services, 2001) in the US health system states:

*Healthcare organizations should implement strategies for recruiting, retaining and promoting at all levels a team rich in diversity and a leadership*

*that together represent the demographic features of the service context.*

At the institutional or organizational level, the most important barriers are related to the representation of ethnic minority members in leadership positions and in the working population in general. The idea is that diversity in leadership positions and among the working population in general would contribute significantly to the development and implementation of appropriate policies, protocols and systems for the care of minority populations. Indeed, it has been shown that the presence of professionals from minority groups leads to high levels of satisfaction among patients (Saha, Komaromy, Koespell, and Bindman, 1999). As one would expect, patients who can communicate with their doctor in their own language show higher levels of satisfaction. Competence at this level thus implies active recruitment and promotion of professionals who represent minority groups.

The situation in Spain is, of course, different, given its considerably shorter multicultural history. At the same time, there is a series of steps that can be taken, such as facilitating the process of homologation and providing incentives for the younger members of minority groups to take up careers in the biosciences or the fields of health or social work.

#### Structural competence

The remaining CLAS items are essentially structural guidelines which healthcare institutions must follow to ensure patients from ethnic minorities receive the same level of healthcare as patients from majority groups. Of course, it is also true that existing structural barriers impede access to health services for majority groups, a phenomenon which is more frequent in systems with private and public healthcare, as is the case in the USA and Spain.

Structural competence is a response to the specific barriers that impede access to quality health services. One of the most important barriers is language (Baylav, 1996; Betancourt et al, 2003; Bowen, 2001; Duffy and Alexander, 1999). Naturally, CLAS emphasizes the importance of the availability of interpreters or cultural mediators, of professionals with a minimum of language skills, and of ensuring that signs, leaflets, forms and all written information in general is available in the languages of the main groups served.

Important though it is, language is not the only structur-



al barrier. A barrier is any aspect of healthcare that contributes to its improper use. Structural cultural competence, then, includes adapting the institution to the needs and customs of the client. This may mean extending opening hours, offering the possibility of receiving attention without prior appointment as an option alternative to appointment-only services, the provision of mobile clinics, and so on. The objective is the creation of a healthcare system that guarantees "total access to quality medical services for all its patients" (Betancourt et al, 2003), so that healthcare services adapt to the needs of their users. This idea contrasts with the notion that the user must adapt to the health system, a view shared by many healthcare professionals.

In sum, structural cultural competencies imply that the whole healthcare system and its institutions must prioritize cultural diversity issues. This implies that best healthcare practice models include the availability of cultural experts for possible consultation, the hiring of interpreters or mediators whenever necessary, the provision of training in this area, and guarantees that the physical space of an institution reflect cultural sensitivity.

#### **Clinical cultural competence**

In the medical literature, clinical cultural competence normally includes cultural sensitivity and knowledge, specialized knowledge and occasionally cultural humility. In general, the medical literature emphasizes knowledge of some illnesses and communication styles, and even the process of communication itself (Betancourt et al, 2003; Health Resources and Services Administration US Department of Health and Human Services, 2001; Like, Betancourt, Kountz, Lu, and Rios, 2001/2002; Misra-Herbert, 2003). To a lesser degree, and mainly in the field of nursing, the recognition of oneself as a cultural being is considered important (Campinha-Bacote, 1999; Purnell, 2000; Tervalon and Murray-Garcia, 1998; Wells, 2000).

#### **MULTICULTURAL COUNSELING COMPETENCIES**

The initial version of Multicultural Counseling Competencies (MCCs) (Sue et al, 1982) was developed in 1982 within the Psychological Counseling Division of the American Psychological Association, and revised in 1992 (Sue, Arredondo, and McDavis, 1992) at the request of the president of the Association for Multicultural Counseling and Development. In 1996, the competencies

were developed a little further (Arredondo et al, 1996), to form the basis of the Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists (American Psychological Association, 2003). The competencies have been supported by the Society of Counseling Psychology Division and the Study of Ethnic Minorities Division, as well as the Association for Counselor Education and Supervision and six further divisions of the American Counseling Association. At present, although not supported by everyone, the competencies have been very well received within psychology in North America.

What differentiates this model from other approaches to cultural competencies is the emphasis it puts on counselors or therapists being conscious of themselves and exploring themselves at a personal level. Counselors are urged to explore themselves thoroughly as an important step in attaining cultural competence.

In any helping or care relationship, but particularly in the relationship with a counselor, certain tacit or subconscious attitudes or one's own beliefs can profoundly affect the result of the counseling process. Those who attend to the public may have a certain level of knowledge of the cultural group with which they are working, and may even have developed appropriate treatment techniques for these groups, but prejudice, often unconscious, can prevent effective help from being provided. This has been proved in studies which show how doctors prescribe fewer analgesics to non-white patients (Green et al, 2003; Tervalon and Murray-Garcia, 1998), and how mental health professionals more frequently diagnose individuals belonging to minorities as suffering from severe mental illnesses (Bhugra, 2000; Lu, Lim, and Mezzich, 1995).

The issue of prejudice cannot be ignored. In multicultural societies such as the United States and Canada people are highly conscious of it, and know how to talk and behave in a politically correct fashion with regard to the matter. The majority of professionals do not wish to be considered as racist and do not see themselves as such. One of the commonest and most uncomfortable aspects in the multicultural debate, particularly when members of the minority as well as the majority group are included, is that of accusations of racism leveled against majority groups. This is often a blow to those making an effort to be antiracist. Research has frequently shown that there is a preference for groups that share common norms, and



an automatic rejection and stereotyped reactions in relation to members of groups whose norms are different (Banaji, Blair, and Glaser, 1997; Dovidio, Kawakami, and Gaertner, 2002).

As with the majority of competence models, the MCCs are based on attitudes and beliefs, knowledge and skills, each one applied to the following areas (Arredondo and Toporek, 2004; Arredondo et al, 1996; Sue et al, 1998):

1. The counselor must be conscious of his or her own cultural values and intolerance or prejudices.
2. The counselor must be conscious of the client's or user's opinion of the world.
3. Appropriate cultural intervention strategies.

The model is complex because of its application of a 3x3 structure, but this was used to emphasize that the three competencies are applicable to each domain; for example, being conscious of oneself is a skill that requires knowledge.

*Counselors must be conscious of their own cultural values and intolerance or prejudices.*

The first area is essentially that of being transparent to oneself, and requires counselors to be actively involved in understanding their own cultural situation and how this influences the way in which they relate to the world. The Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists, published in 2003 by the American Psychological Association, summarize this point very well in Guideline 1 (American Psychological Association, 2003):

*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.382).*

Recognition of this requires total commitment when looking at and understanding oneself in relation to one's own cultural dimension. It forces us to take a searching look into our cultural heritage in order to develop a positive racial identity. In short, competence in this field requires that one wishes to get to know one's own cultural dimension in order to understand how this shapes our interactions with others and enable us to take the necessary steps to further the process in a positive way. This self-awareness includes examining how we are affected by racism and discrimination, and how in consequence

can hold racist or prejudiced attitudes and beliefs. For members of majority groups, this requires the exploration of privileges and benefits accruing merely through being identified as members of the majority group. Benefits that are the fruits of racism and found in individuals, institutions and culture. This clearly an ability and a will to involve oneself in a process of exploration that is neither comfortable nor socially desirable, but which is considered essential for effective intercultural work. Finally, this competence includes the awareness and understanding of how one's own cultural and racial position affects users.

### **Understanding the patient's perspective**

This area is an essential part of attaining intercultural empathy. The culturally competent counselor or therapist must attempt to understand the user's perspective and, although not always sharing their expectations and perspectives, should at least respect and appreciate them. Competence in terms of attitudes and beliefs implies the above-mentioned self-transparency, as well as the skills that allow negative judgments and emotional reactions towards patients to be observed and controlled.

Understanding the patient's perspective obviously involves having a sufficient level of cultural knowledge, which consists of three parts:

- First, profound knowledge of the patient's culture, cultural heritage and personal history. Given that cultural knowledge is nomothetic, and that belonging to an ethnic or racial group is a demographic, not a psychological fact, the Multicultural Counseling Competencies clearly recognize the use of the identity models described above as a means of individualizing cultural knowledge and giving it greater behavioral and psychological significance.
- Cultural knowledge, in the Multicultural Counseling Competencies, also implies an awareness of how race and culture influence people, not only in relation to general concepts such as psychosocial development, but also to concrete concerns of mental health, such as representations of distress, help-seeking behaviors or expectations regarding the counseling process.
- Finally, competence in terms of cultural knowledge implies an understanding of the influence of socio-political and economic factors on the lives of minority group members.



Competence in skills in this field essentially involve an active search for the education and experiences necessary for developing cultural empathy.

### Culturally appropriate intervention strategies

This is the most “concrete” of the three areas, and perhaps that which generates most interest among healthcare professionals, since it determines what one should do when working with patients from different cultures. This area cannot, however, be expected to serve as a “cookbook” in which the professional can find the appropriate recipe for each user depending on his or her cultural or ethnic background. What it actually provides are the attitudes, beliefs and skills necessary for effective interventions, without ever describing the interventions as such.

The starting point for effective intervention is the requirement that professionals respect the user. This implies respect for beliefs regarding the distress or problem as well as the possible solutions suggested by the patient. Competence in this area implies general knowledge of the normal care-giving approaches in the majority group, the institutions involved, and the ways in which these are culturally biased, which can impede efficiency, either because they impede access or because lead to a culturally inappropriate service.

Flexibility is fundamental in any skills competence. The counselor has to adapt to the needs and wishes of the patient, always within the appropriate ethical framework. Culturally competent counselors have no difficulty in applying their knowledge of different communication styles; they have to be experts in correctly interpreting signs, both verbal and non-verbal, and the messages transmitted by patients; and they must be able to respond in a comprehensible manner to their patients. The counselor's intervention should match the needs of the patient, more than the professional's philosophy, although flexibility does have limits, and professionals need to know their own limits and when the patient should be referred. Similarly, the competent professional can discern the difference between cases that require more social or more institutional treatment, and is capable of taking the necessary steps to ensure that the treatment is carried out. Flexible and effective treatment means not only knowing when patient referral is necessary, but also when to consult a representative of traditional/folk medicine, or spiritual or community leaders, in an attempt to adapt the service to the needs of the user. At the same time, the

professional obviously needs to ensure that the service is offered in the preferred language of the patient. This may mean making the necessary patient referral or ensuring the availability of cultural mediators.

It is important to emphasize that, although flexibility is important, the services must be consistent with the counselor's competencies; moreover, the services offered, however flexible, should not go beyond the limits of counseling or psychotherapy. It is essential that the professional informs and educates the patient about the nature of the treatment to be carried out and what it involves. Many people have no experience of psychotherapy, and therefore have no idea what it can offer them. Effective communication and treatment require a mutual understanding of what is being done (Table 1).

It is undoubtedly difficult for many of us to adopt the “native's point of view”, and there is a tendency to put forward arguments from other perspectives. Cultural competence, however, demands that we do not impose our values on patients, but that we accept them as reasonable and intelligent people.

### DISCUSSION

It is important to point out that competencies in multicultural counseling do not replace or substitute the skills already in use in counseling. Despite their critical view of

**TABLE 1**  
**APPLICATION OF COMPETENCE IN**  
**ATTITUDES AND BELIEFS**

#### **The Moroccan couple**

A Moroccan woman has an appointment with her psychologist and arrives with her husband. Each question directed by the doctor to the woman is answered by the husband. The woman remains seated with her head down, avoiding any visual contact with the psychologist. How should this be interpreted? It might be seen by many as a clear example of sexism, inherent in Arab and Muslim cultures, and that the husband is a chauvinist trying to control his wife. Applying cultural competence, the psychologist must first of all recognize his prejudices towards the couple and Arab and Muslim cultures, as well as identifying the possible bias of this analysis based on Western principles. Next, the psychologist must try to apply cultural empathy, that is, understand the behavior of the patient from her perspective. Could another explanation be found? Might the husband simply be doing what his culture dictates? Could it be that what the husband is actually doing is taking responsibility for his wife's well-being?



existing Western models, the MCCs do not offer an alternative approach to counseling, other than broadening the role of the counselor. The specific approach has reached the doctor-patient level, but it is not clear, given the nature of the criticisms, to what extent it can serve as the conventional approach. At the same time, it is evident that the MCCs do not propose to sidestep conventional psychology – indeed, the operative system remains a firm part of the traditional approach, though with some modifications. What the multicultural counseling competencies offer above all is an orientative paradigm, allowing counselors to sensitize themselves to aspects which, if effectively covered, can make the service more sensitive to members of ethnic minority groups.

What is clear is that institutional and structural cultural competence form the basis of clinical cultural competence. While it is true that individuals can make the effort to reach this level of expertise using a model such as the MCCs, unless their clinical or therapeutic institution and the health service authorities support the process, cultural competence will simply remain at the individual level, rather than being a phenomenon with the power to truly coordinate and integrate. The availability of cultural mediators, the recruitment of professionals from ethnic minorities, the structural modifications designed to adapt the services to the cultural needs of users, access to cultural consultants and ongoing training in cultural competencies require a serious commitment on the part of the administration and the institution. At an individual level, cultural competence requires something more than a mere accumulation of knowledge and a desire to help interesting people. It also takes the courage to commit oneself to serious reflection on one's own prejudices and bias.

Given the present Spanish panorama, with a marked development towards an increasingly multicultural society as a direct consequence of migratory phenomena in constant progression, there should be a growing realization of the importance of cultural competence. For obvious historical reasons, this has not previously been an issue of concern for healthcare professionals in general or those working in mental health in particular. Nevertheless, the demographic tendency towards multiculturalism demands a rethink, and poses the challenge of offering a similar level of service quality to all users of the healthcare system, independently of their ethnic or cultural background. Consequently, it seems reasonable to consider that any mental health service unit in the Spanish context should soon include cultur-

al competence in its quality criteria. The American model presented in this article need not to be the one to follow. Up to now, no model can be said to have attained perfection, and we therefore have none to serve automatically as a reference point for our context. The features of Spanish society, its ethnic groups, the migratory phenomenon, its geographical location, its health system, and so on, mean that none of the currently available models can be applied just as they are, without an effort of adaptation, flexibility and, indeed, imagination, in line with the contextual conditions.

Note: The article is based on the lecture: "The model of cultural competence (United States and Canada) and its application in the field of drug abuse." 2nd Conference on Cross-culturality at the XAD, Department of Health and Social Security, General Directorate of Drug Addiction and AIDS, Catalan Regional Government, March 2004, Barcelona.

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