Cultural Competence Reexamined: Critique and Directions for the Future

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This Open Forum aims to stimulate productive dialogue about cultural competence in providing mental health care. The authors examine recent calls for culturally competent care in mental health practice and give a brief overview of the context in which demands for such care have arisen. Using select examples from anthropology, the authors provide evidence of the importance of culture in the production, presentation, and experience of psychic distress. Acknowledging the value of culturally appropriate care, the authors synthesize anthropological critiques of cultural competence models. The essay concludes with suggestions for future directions in cultural competence research and implementation. (*Psychiatric Services* 58:1362–1365, 2007)

The contemporary practice of mental health care demands an acknowledgment of the role of culture in the mediation of psychopathology. Indeed, "culture counts" was the main message of the Surgeon General's 2001 report on culture, race, and ethnicity (1), and research by medical an-

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thropologists and cross-cultural psychiatrists has demonstrated that culture is central in nearly all aspects of mental disorders (2,3).

Mental illnesses present particular challenges in matters of diagnosis and identification. Pathological psychic experiences must be distinguished from their "normal" counterparts. The ephemeral nature of everyday emotional and psychic life further complicates identification. This inherently complex process is made even more difficult when one factors in differences in ethnic and cultural background and language barriers. Recognition of such difficulties has informed recent demands for cultural competence in clinical practice.

Our goal for this piece is to stimulate productive dialogue about cultural competence. We begin with an overview of recent calls for culturally competent care. Next, we present select examples from the anthropological record to underscore the importance of culture in the production, presentation, and experience of psychic distress. Acknowledging the deep value of culturally appropriate care, we then synthesize anthropological critiques of current models of cultural competence. Finally, we offer suggestions for future directions in cultural competence research and implementation, highlighting the importance of interdisciplinary collaboration.

A brief note about culture, race, and ethnicity

A significant limitation of much biomedical literature, including works reporting on cultural competence efforts, is the inexact use of the concepts of culture, race, and ethnicity

(4). Before moving forward in our discussion, it is necessary to make a brief digression on these points. First, to clarify what we, as anthropologists, mean by culture, we follow the analysis of Jenkins and Barrett (3) and understand culture to be, most broadly, the "shared symbols and meanings that people create in the process of social interaction," which orient "people in their ways of feeling, thinking, and being in the world." Second, although "race" and "ethnicity" are often used interchangeably, race usually refers to shared physical characteristics of a group and ethnicity to identification with a presumed shared heritage (5). Maintaining an analytic distinction between race and ethnicity acknowledges that "perceptions of racial difference form one of the most fundamental divides in social life" (5) and thus calls attention to the unique challenges, wrought by deeply entrenched discrimination, that Americans from racial minority groups continue to face. Thus race and ethnicity must not be used uncritically and need to be acknowledged as historically and culturally situated concepts (4,6). (The American Anthropological Association's Race Project is a resource for those seeking more thorough coverage of these issues. Its Web site, raceproject.aaanet.org, provides a comprehensive bibliography on the subject.)

Cultural competence: an overview

Goals of culturally competent care include "creat[ing] a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, eth-

nicity, culture, or language proficiency" (7). Likewise, "the idea of cultural competency is an explicit statement that one-size-fits-all health care cannot meet the needs of an increasingly diverse American population" (8). Cultural competence operates at an individual level in the application of specific techniques and skills in the context of clinical encounters and at an institutional level in the promotion of organizational practices to meet the needs of diverse populations.

Calls for cultural competence are rooted in the increasing diversity in the United States (7,8). Changes in national demographic data are yielding changes in clinical populations. Clinicians are likely to treat patients who may have limited English-language proficiency, have different care-seeking behaviors, and hold different expectations for care (7). More broadly, there is increasing awareness of dramatic health disparities among ethnic minorities in the United States. Not only do these populations bear a disproportionate burden of mental illness, they also are less likely to have access to, and receive, needed services; often receive poorer-quality services; and remain underrepresented in mental health research (1,9). To redress these disparities, culturally appropriate services have been found to promote service utilization and treatment adherence (10).

Why culturally appropriate care is important

The provision of culturally appropriate care is a worthwhile goal. Indeed, much of the medical and psychological anthropological record offers up cautionary tales of the potential for deep misunderstandings to occur in clinical encounters. For example, evidence from research in Sri Lanka shows that a Western person with major depression would likely be considered a "good Buddhist" because of different cultural orientations to the nature and meaning of suffering (11). Similarly, complaint and suffering may constitute ennobling social practices within the Catholic Mediterranean tradition (12). What may appear as hallucinatory visions of deceased relatives from the point of view of most North Americans may in

fact be a normal bereavement experience for many American Indians (2). Among Salvadoran female refugees, *el calor,* a sensation of intense heat in the body, can create significant clinical confusion (13). This culturally distinctive syndrome is often misdiagnosed as menopause or high blood pressure and a range of psychiatric disorders (13).

Misunderstanding culture: critiques of cultural competence models

Although researchers recognize the crucial importance of culture in the experience and treatment of mental disorders, models of cultural competence nevertheless fall short on several counts. Some of the anthropological critiques of such models are that they frequently present culture as static; treat culture as a variable; conflate culture with race and ethnicity; do not acknowledge diversity within groups; may inadvertently place blame on a patient's culture; often emphasize cultural differences, thereby obscuring structural power imbalances; and finally, fail to recognize biomedicine as a cultural system itself. We elaborate below on each of these points.

A fundamental problem of cultural competence models—that they often present culture as fixed or static—provides the background to many of our other criticisms. Anthropologist Janelle Taylor has trenchantly critiqued *The Spirit Catches You and You Fall Down* (14), accusing the "canonical text for cultural competence efforts" of using a "reified, essential, static" understanding of culture that is inconsistent with current culture theory within anthropology (15). Consequently, culture is not viewed as a dynamic, ongoing process and an emergent product of human interaction. In a similar argument, anthropologist Susan Shaw has pointed out that "narratives of culture" in health services that are based on the idea of essential differences between groups of people promote the "commodification and reification of culture" (16). As a result, culture is understood as a property of "certain" individuals, for example, those of racial and ethnic minority groups. Thus many cultural competence models are guilty of what Jenkins and Barrett

(3) called an attempt to "reduce [culture] to something it is not, a quantifiable 'cultural factor' or a 'cultural variable.'"

Oversimplifications of the concept of culture may conflate culture with race or ethnicity. Notions of culture based on race and assertions of fundamental differences among ethnic groups are often the basis for cultural competence efforts, particularly those characterized by attempts to achieve "ethnic resemblance" between patient and provider (16,17). Stagnant views of culture fail to effectively address diversity within cultural groups and leave little room for cultural change (15,16,18). As Lee and Farrell (19) have argued, the inability of cultural competence models and programs "to capture the diverse and fluid nature of culture and self-identity" only reifies existing racial categories rather than deconstructing barriers to health care. Furthermore, without recognition of the flexible, emergent quality of culture, such efforts fail to adequately account for cultural variation (16,18). One result is that one-size-fits-all mobilizations of "culture" may lack relevance for clients as well as practitioners (16).

With minority status in the foreground of definitions of culture, we potentially ignore other important sources of health disparities. Some have advocated integrating minority status alongside considerations of socioeconomic status and geographic region and caution against attributing sources of disparities in mental health care utilization to the effects of race or ethnicity alone (20). In a similar vein, Lambert and Sevak (21) warned against the oversight that may exist in medical encounters between recognition of cultural differences and perceived deviance from a middle-class, Anglo norm. Ortner (22) has warned that class remains "hidden" in the United States even if there is an acknowledgment of a fusion between race, ethnicity, and class. Indeed, other factors, including class, gender, generation and age, and geography, may in fact be equally or more important than race or ethnicity to an individual's identity (23).

Naïve applications of culture in

clinical practice may also unintentionally blame the patient's culture for miscommunication, nonadherence to clinical recommendations, and other challenges to effective treatment. For example, Santiago-Irizarry (18) has identified a tension in efforts to deliver culturally sensitive psychiatric practice. Although such efforts may be understood as attempts to redress medical hegemony, Santiago-Irizarry averred that such efforts may become problematic if ethnically normative behaviors are rendered as psychological symptoms (2). She also critiqued the construal of the Hispanic population as being especially at risk of mental illness. Identifying vulnerability as a double-edged sword, Santiago-Irizarry wrote that such characterization seems to indicate a contradictory understanding of culture. Culture is seen as being both a source of problematic behavior and the solution to all the difficulties encountered in clinical practice with underrepresented populations (18).

Important structural features common across clinical encounters may be obscured by continual emphasis on cultural difference. In fact, power imbalances may be endemic to patient-provider interactions (24–28), and breakdowns and slippages in communication can tell us much about the assumptions ensconced within contemporary medicine (29). As Good and colleagues (30) have noted in their discussion of the training and socialization of physicians, the medical view quickly becomes the principal knowledge frame in medical school, with efficiency highly valued. The result of this cultivation is that medical students and attending physicians are often "most caring of patients who are willing to become part of the medical story they wish to tell and the therapeutic activities they hope to pursue" (30). As such, obstacles in clinical communication are experienced not only by minority groups, but miscommunication may be more pronounced among them (7). Rather than focusing on specific cultural differentials in health care experiences, a more useful enterprise may be to interrogate the rift between biomedicine and lay understandings of health and illness (21,31).

In this regard, by emphasizing the culture of patients, cultural competence models often fail to recognize Western biomedicine as a cultural construction to be considered within a historical context (32). For example, by tracing the historically situated classifications in the *DSM*, Gaines (32) has argued against a universal view of psychiatric disease categories. Demonstrating how disease definitions have changed over time, he argued instead that the *DSM* is a product of a particular professional and culturally contingent ethnopsychiatry rather than a culture-free science. In this respect, discussions of cultural competence must not be limited to consideration of the patient's background and language proficiency but must also recognize the culture of medicine itself. Recognizing that clinical encounters entail engagement with the language and culture of medicine will broaden conceptions of the importance of culture in mental health services beyond that of interpreters or culture brokers.

Future directions for cultural competence

The practical reality of contemporary mental health practice involves challenges inherent in diagnosis and effective treatment as well as burdens posed by substantial time and economic constraints. Clinicians may be understandably overwhelmed by a detailed, nuanced patient story in the context of such pressures. The challenge, therefore, is how to contend meaningfully with the social and cultural worlds of patients given these practical realities so as to provide the most effective treatment interventions.

In our opinion, cultural competence efforts would benefit from a more sophisticated, anthropologically informed conceptualization of culture. In this Open Forum, we have synthesized a series of anthropological critiques of what is broadly a trait-based employment of culture. We feel that advances in culture theory are germane to a consideration of cultural competence. Of particular relevance is the sea change between behavior-based orientations to culture—in which culture was understood to be located in patterns of ac-

tion and customs (33)—and meaning-centered approaches—in which culture is understood as a dynamic process of shared meanings, located in and emerging from interactions between individuals (3). The danger of a behavior or trait-based understanding of culture is that it may tend toward stereotyping of minority populations. In contrast, a process-oriented approach emphasizes dynamism and flexibility as key dimensions of culture. Greater appreciation by mental health professionals of the complexity and indeterminate nature of culture would facilitate clinical encounters characterized by openness and a willingness to seek clarification when patients present with unusual or unfamiliar complaints.

Medical anthropologists are known for their critiques of contemporary medicine (25,34,35). The current milieu of cultural competence in mental health services creates a new venue in which to apply our expertise as students of culture. In this regard, it is crucial, however, for anthropologists to move beyond ivory-tower critique and toward clinically relevant and practical recommendations. An exemplar and, indeed, a pioneer of the application of anthropological insight in mental health practice is anthropologist-psychiatrist Arthur Kleinman (36), who has advocated for decades the incorporation of anthropological technique into clinical practice. For readers interested in a specific application of anthropological technique, please see Kleinman and Benson's (37) recent recommendations for a "mini-ethnography." More frequent collaborations between clinicians and students of culture will facilitate efforts to provide culturally appropriate services. Through in-depth ethnographic studies of mental health organizations, anthropologists could contribute knowledge of how cultural competence is understood and deployed on the ground. Clinicians' perspectives will provide first-hand accounts of the principal challenges they face in the provision of care to diverse populations. Moreover, the inclusion of consumer perspectives is a crucial dimension in the development of patient-centered and culturally relevant practices.

Conclusions

In this Open Forum, we have used the anthropological lens to examine and inform ongoing dialogue and debate about cultural competence. Many cultural competence efforts construe culture as something to know rather than something to be ready for. We argue, however, that an encyclopedic knowledge of the world's cultures and their specific systems of knowledge regarding health and illness is not a requirement for the provision of culturally appropriate care (38). Likewise, effective incorporation of culture in clinical practice will not construe it as yet another technical skill for clinicians to acquire (37).

Two systems of knowledge collide in clinical encounters. Clinicians are experts in biomedicine; patients are experts in their own experience of distress. Thus clinical encounters ought to be viewed as two-way learning encounters. To achieve this goal, we recommend that clinicians remain open and willing to seek clarification when presented with unusual or unfamiliar complaints. In short, following others (36,39), we advocate the incorporation of anthropological techniques into clinical practice as a means to realize truly culturally appropriate care.

Acknowledgments and disclosures

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