EXPLORING MENTAL HEALTH CARE PROVIDERS’

EXPERIENCES AND IMPLEMENTATION OF CULTURAL COMPETENCE

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**ABSTRACT**

**Objective:** As Canada’s population becomes more diverse, it is becoming increasingly important that health care providers are able to practice across cultural differences. This thesis aims to provide insight into how academic institutions teach health care professionals about cultural influences on mental health and clinical encounters, as well as how health care providers implement these ideas in their work.

**Methods:** This research was conducted using a qualitative content analysis methodology. Fifteen semi-structured interviews were conducted with mental health care providers in Hamilton. Interviews were recorded and transcribed verbatim, and data was then coded and analyzed using a lens informed by discourse theory.

**Findings:** Providers varied significantly in their definition and experience of cultural competence. Few providers had received training in cultural competence, and the experiences of those who had received such training were generally not congruent with what is described in the literature. While the literature describes a shift towards a skills-based paradigm, health care education appears to continue to focus on knowledge and attitudes. Many providers are more familiar with other frameworks for addressing cultural issues; however, these have important implications for practice.

**Conclusion:** Cultural competence has not been implemented in the manner recommended in many guidelines. Health care providers may require additional support if they are to understand and implement these concepts as described in the literature.

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# CHAPTER 1: INTRODUCTION & BACKGROUND

Culture plays an important role in many aspects of illness, including both biological and sociological processes. Not only does culture influence the interactions between patient and health care provider, but culture also plays a role in determining patients’ exposure to risk factors for mental illness, how patients experience their illness and its treatment, and how their illness affects other social dimensions of their lives. In the past, mental health care providers could largely assume that patients came from similar cultural backgrounds and that their risk factors and the manifestation of their symptoms would consequently be somewhat homogeneous (Minas, 2000). However, with increasing diversity and migration, discerning “abnormal” behaviours and appropriate treatment goals has become more complex (Gaines, 1992; Kirmayer, 2007b).

Cultural competence has emerged as a new paradigm to guide how professionals should work in cross-cultural situations. Common definitions of cultural competence state that it is a “set of congruent behaviours, attitudes, and policies” related to the provision of equitable care to minority populations (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Cross, Bazron, Dennis, & Isaacs, 1989; Denboba, Bragdon, Epstein, Garthright, & Goldman, 1998). Cultural competence is also often defined as relating to providers’ skills and ability to apply knowledge and awareness of cultural differences (American Association for Health Education, 1994; National Medical Association, 2010). However, there is no set definition for cultural competence, and there is significant variation in how schools and professional disciplines teach it. Standards and best practices in cultural competence training are largely non-existent (Bassey & Melluish, 2013; Beach et al., 2005). This research project seeks to explore how mental health care providers in Hamilton understand cultural competence and what they do to provide care they perceive as being culturally competent.

## 1.1. RESEARCH CONTEXT

### 1.1.1. What is Cultural Competence?

Support for cultural competence in health care has grown as health care providers and policy-makers increasingly acknowledge racial and ethnic disparities in health and recognize the impact of culture on health beliefs and behaviours, disease, and treatment outcomes (Betancourt et al., 2003). In response to inequities in health care access and outcomes, academic institutions have increasingly incorporated cultural competence into training programs for health care professionals. However, training models vary significantly in their conceptualization of culture and in the strategies they suggest health care providers use to overcome challenges related to cultural differences (Owiti et al., 2013). Overall, the term cultural competence remains vague and poorly defined (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Qureshi, Collazos, Ramos, & Casas, 2008). In general, however, there is consensus that in order to improve professionals’ ability to provide health care to diverse populations, cultural competence training programs should target health care providers’ knowledge, skills, and attitudes (Bassey & Melluish, 2013; Beach et al., 2005; Bhui et al., 2007; Kirmayer, Fung, et al., 2011). Providers who are culturally competent have a greater awareness of how society and culture influence patients and their experiences (Beach et al., 2005). This awareness improves their ability to negotiate different explanatory models and establish trusting relationships that supersede culture (Bassey & Melluish, 2013; Beach et al., 2005).

### 1.1.2. Why is Cultural Competence Important?

The need for culturally competent health care arises in part from the fact that health and sickness are culturally and socially constructed experiences (Kleinman, Eisenberg, & Good, 2006). Biomedicine, the school of thought that underpins Western health care systems, is predicated on the notion of evidence-based medicine, which seeks to provide best practices for a universal patient body (Kirmayer, 2012a). It therefore often ignores the cultural and social factors that contribute to health and illness (Edge & Newbold, 2013; Kirmayer, 2012a). Kleinman (1980) suggests that while biomedicine may be adequate in treating the malfunctioning of biological processes, this is only one of two aspects of sickness. In contrast to the “disease” element of sickness, “illness” involves the shaping of a disease by personal, social, and cultural reactions, which ultimately leads to its manifestation in a person’s experience (Kleinman, 1980; Kleinman et al., 2006). Often, physicians’ and patients’ understandings of sickness and treatment differ because while physicians focus on disease, patients’ explanatory models are more oriented towards illness and cultural and social experiences (Kleinman, 1980). Consequently, patients’ concerns are often reduced to what is deemed clinically relevant from the perspective of the physician, and psychosocial and cultural factors that play an important role in the experience of illness are ignored (Watters, 2001).

Discrepancies between the explanatory models of physicians and lay-people can detrimentally affect the treatment of any patient. However, the biomedical paradigm has a greater influence on explanatory models in Western societies. In contrast, non-Western medical traditions often consider illness and sociocultural influences to a greater extent (Kleinman, 1980). Consequently, migrant patients may be more likely to feel that important elements of care are being omitted and may be dissatisfied with their interactions with health care providers (Weerasinghe & Mitchell, 2007). By improving physicians’ ability to negotiate between and accommodate different explanatory models, cultural competence improves therapeutic relationships and therefore contributes to better compliance and treatment outcomes (Edge & Newbold, 2013).

Moreover, patients are less likely to disclose the use of traditional medicines and complementary alternative therapies if they perceive their health care provider as being culturally insensitive (Dyck, 1995). Cultural competence can improve communication with regards to the use of alternative (and possibly conflicting) treatments by encouraging providers to inquire about other methods of illness management and by improving the therapeutic relationship in a way that makes patients more comfortable discussing alternative treatments. Cultural incompetence and systematic inattention to illness experiences lead to poor communication and misunderstandings, lower rates of compliance and follow-up, and poorer health outcomes (Edge & Newbold, 2013; Kleinman et al., 2006; Wood & Newbold, 2012). In fact, the mere *expectation* that Western-trained physicians will be culturally incompetent is a barrier to accessing health care for many migrant patients (Donnelly et al., 2011; Lawrence & Kearns, 2005).

## 1.2. RESEARCH QUESTIONS & OBJECTIVES

Given the lack of consensus over how to best provide care in multicultural settings, this thesis research project seeks to shed light on how mental health care providers in Hamilton understand and experience cultural competence. This study focuses on mental health care providers in particular, as research suggests that migrants are at increased risk for developing mental illness, and that stigma may disproportionately prevent migrants from seeking care for mental health problems.

The research described in this paper has been guided by two primary research questions and related sub-questions:

1. How do mental health care providers learn about cultural competence?
* Where does this learning take place?
* What do mental health care providers learn about culture?
* Do mental health care providers perceive this learning as useful?
1. What does “cultural competence” mean to mental health care providers?
	* What do mental health care providers do to provide culturally competent care?
	* What are mental health care providers’ thoughts and opinions about cultural competence?

These questions aimed to provide insight into how academic institutions teach health care professionals about cultural influences on mental health, as well as how health care providers experience and implement these ideas.

## 1.3. STUDY LOCATION

 This study was conducted in mid-sized city of Hamilton, Ontario. Hamilton is located about 60km west of Toronto. Of the 504,560 people living in the City of Hamilton, approximately 25% were born outside of Canada (The Social Planning and Research Council of Hamilton, 2011). Hamilton’s municipal government is actively involved in encouraging immigration to the city, and created the Immigration Partnership Council in order to “help build a more inclusive city that will attract and retain a greater share of immigrants to Canada,” (The Social Planning and Research Council of Hamilton, 2011). Hamilton is also home to as many temporary migrants as permanent residents, most of whom are foreign students (Hamilton Immigration Partnership Council, 2013). Recently, the proportion of immigrants from Asia (primarily the Philippines, China, India, Iraq, and Pakistan) has increased while the proportion of immigrants from Europe and the United States has decreased (Hamilton, 2015; Hamilton Immigration Partnership Council, 2013). In fact, with a visible minority population of 101,600 individuals, Hamilton has the eighth largest visible minority population in Canada (Statistics Canada, 2013).

## 1.4. CHAPTER OUTLINE

 This thesis report includes six chapters. The current introductory chapter includes a description of the research question and objectives, as well as general background information on cultural competence. The second chapter consists of a review of the literature, which includes publications that define cultural competence and make recommendations regarding cultural competence training, studies that explore the interactions between culture and mental health, and studies that aim to measure the impact of cultural competence training. Chapter three provides an overview of the methodology used in this study. It includes details about the sampling and data collection strategies used, and the theoretical framework that guided the subsequent analyses. The results of the study are detailed in chapter four and discussed in more detail in chapter five. Chapter five also includes a discussion of the study’s limitations, as well as recommendations for the implementation of cultural competence and for future research.

## 1.5. BACKGROUND

### 1.5.1. Mental Health and Culture

 As Canada’s population becomes more multicultural, health care providers increasingly encounter migrant patients, including both immigrants and refugees. It is increasingly important that mental health care providers understand the diverse factors that can affect individuals’ experiences of mental health (Minas, 2000). The following section provides an overview of five key areas of care that may require additional attention to cultural factors: social determinants and risk factors, symptomology, help-seeking behaviours, diagnosis, and treatment.

#### Social Determinants and Risk Factors

 Cultural competence in mental health is important because in comparison to the overall population, migrants are disproportionately exposed to risk factors for mental illness in relation to the general population (Beiser, 2005). Exposure to such risk factors can occur before, during, or after the migration process (Kalanga & Tshisekedi, 2008). Pre-migration risk factors vary greatly among migrant patients. For instance, while economic migrants have chosen to leave their country, refugees are forced to flee dangerous and tragic situations (Kalanga & Tshisekedi, 2008). Depending on the circumstances of their departure, migrants may have been able to prepare for the migration process to varying degrees. Regardless, however, stress related to the loss of personal possessions and separation from family and friends is inevitable (Kalanga & Tshisekedi, 2008). Refugees may also have been subjected to torture or other traumatic experiences, which can result in post-traumatic stress disorder and depression long after resettlement (Beiser, 2005). Some individuals may be forced to live in camps for internally displaced persons or refugees prior to their resettlement, or may be detained upon arrival in their host country; such experiences add to the risk of developing mental disorders (Beiser, 2005). Providers who isolate clinical symptoms and fail to address the context of their patients’ experience risk medicalizing normal responses to distress and may not be able to address the roots of their patients’ illnesses (Jacob, 2013).

 The processes of adaptation and acculturation are fraught with challenges and stresses that can increase the risk of developing mental illness. While the prevalence of mental illness is actually lower among new migrants than among the Canadian-born population, migrants are at an increased risk of developing depressive disorders in the period of 10-24 months after migration (Ali, 2002; Beiser, 2005). Analyses of the Canadian Community Health Survey by Ali (2002) showed that among immigrants who had lived in Canada for 10-14 years, the prevalence of mental illness had increased to match the prevalence among the Canadian-born population. Similarly, De Maio and Kemp (2010) examined data from the Longitudinal Survey of Immigrants to Canada and demonstrated increasing levels of self-reported mental health problems among immigrants. Aside from the surfacing of repressed memories, this increase in mental disorders among migrants may also be the result of disproportionate exposure to risk factors for mental illness or an increased awareness of mental health issues and the language to discuss them (Beiser, 2005; Beiser & Fleming, 1986; O'Mahony & Donnelly, 2007a). After arriving in their country of resettlement, migrants may be faced with prejudice, discrimination, and racism, which hinder integration and are associated with an increased prevalence of mental distress (Brown et al., 2000; De Maio & Kemp, 2010; Kalanga & Tshisekedi, 2008; Noh & Kaspar, 2003; Williams, Neighbors, & Jackson, 2003). In comparison to the Canadian-born population, immigrants are significantly more likely to be unemployed and to live in poverty (Beiser, 2005). High levels of immigrant unemployment are both a result of a lack of recognition for foreign credentials and of discrimination in hiring practices (Beiser, 2005). As migrants’ ambitions and expectations for resettlement are frustrated, their mental wellbeing is jeopardized. Moreover, not only do illiteracy and poverty increase the likelihood of developing a mental illness; these factors are also barriers to accessing care and predictors of non-adherence to treatment (Beiser, 2005; Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008).

 By increasing providers’ awareness of such contextual factors, training in cultural competence discourages the use of medicine-based solutions that medicalize normal reactions to stressful situations (Jacob, 2014). An understanding of racism and power disparities also helps providers to reflect on their own prejudices and advocate for policies that address social exclusion at the institutional level (Kirmayer, Fung, et al., 2011). Similarly, culturally competent providers are aware of the impact of colonization and forced assimilation on indigenous groups, and are better equipped to address the inequities in social arrangements and persistent demoralization that can result from these lived experiences (Gone, 2007; Kirmayer, Fung, et al., 2011).

 Conflicts between the individual’s heritage culture and Canadian culture can also be a source of stress (Berry, 1997). Migrants who respond by abandoning their culture and adopting Canadian culture may experience a sense of loss, while those who reject Canadian culture in favour of their heritage culture may become isolated. Ideally, the two cultures can be blended; however, this outcome is not always achieved. Indeed, in some cases, both the old and the new culture are rejected, leading to marginalization and the highest risk of experiencing mental distress (Beiser, 2005; Berry, 1997).

 It is important to note that while most migrants are exposed to these stressors, only a small minority develop mental illness; exposure to risk factors does not necessarily determine the mental well-being of a patient and it is important to avoid assuming that all newcomers suffer from mental illness (Beiser, 2005). However, by exploring how these factors may contribute to patients’ mental wellbeing, culturally competent providers are better able to understand the experience of their patients and develop a treatment plan that addresses their unique needs.

 Finally, culturally competent providers must also be aware that migrant patients may have been exposed to different risk factors or social determinants of mental health in ways that are completely unrelated to the migration process. According to Henningsen and Kirmayer (2000), an individual’s neural circuitry is shaped by his or her interactions with their environment. These interactions shape patients’ biology and may cause some groups to be at a higher risk for particular disorders. As the Canadian population becomes more diverse, it is increasingly important for providers to recognize that their patients come from diverse environments, and that this diversity may have implications for the prevalence of certain diseases.

#### Symptomology

 As a consequence of the dominance of the biomedical model, diseases are largely viewed as biological phenomena. Biology is assumed to be universal; therefore it is often assumed that there is little cross-cultural variation in the symptoms of disease (Gaines, 1992). Moreover, mental health care providers are encouraged to follow evidence-based practice, which demands the use of standardized interventions that are based on sound evidence from randomized clinical trials (Aisenberg, 2008). However, these clinical trials may not always use samples representative of all cultural or ethnic groups. Not only does culture affect individuals’ risk of developing mental disorders, it can also shape the symptoms that are exhibited. In a landmark article based on his field research in Taiwan, Kleinman (1977) presented evidence of significant cross-cultural differences in the features of depressive disorder. His research suggested that these differences are reflective of cultural constructions of normative and deviant behaviours. Kleinman (1977) argues that while some patients from cultural minorities will fit the symptoms and definition of depression that has been constructed and used by Euro-American psychiatrists, these patients represent only a small fraction of the population suffering from depression, and that the many patients whose symptoms do not correspond to this cultural category are misdiagnosed. This finding was confirmed in a British study by Bhui, Bhugra, Goldberg, Dunn, and Desai (2001), which found that Punjabis with common mental disorders were more likely to be diagnosed with sub-clinical disorders or as having physical and somatic symptoms, while English men and women were more likely to be correctly diagnosed. Similarly, Neighbors, Jackson, Campbell, and Williams (1989) found that depression was less likely to be diagnosed in black Americans than in their white counterparts.

 Patients’ explanatory models also play an important role in determining how an illness is exhibited. Based on cultural models, individuals may seek out and identify symptoms that fit their explanatory model of illness (Kirmayer & Sartorius, 2007). Somatic complaints may also be seen as more legitimate; these complaints may be given the most attention, while socio-emotive dimensions of illness are ignored because they are stigmatized (Beiser & Fleming, 1986; Kirmayer & Sartorius, 2007; Kirmayer & Young, 1998; Kleinman, 1977; Neale & Wand, 2013). Among some cultures, physical complaints are used as metaphors that allow patients to indirectly express concerns related to their mental wellbeing (Kleinman, 1977; Neale & Wand, 2013).

Trauma associations or memories, cultural expectations, cultural metaphors, and culture-specific idioms of distress can all play a role in determining how mental disorders are manifested (Hinton & Hinton, 2002; Hinton, Hinton, Pham, Chau, & Tran, 2003; Kirmayer & Sartorius, 2007). It is therefore important that mental health care providers are sensitive to cultural differences in the manifestation of mental illness, and are equipped to look beyond the results of screening instruments and diagnostic criteria that are based on the culture of majority (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010; Dressler & Badger, 1985; Huang, Chung, Kroenke, Delucchi, & Spitzer, 2006; Vega & Rumbaut, 1991). In the aim of developing a therapeutic relationship, it is also important that providers elicit information from their patients about the significance of their symptoms; otherwise, providers may inadvertently trivialize patients’ experience by focusing only on symptoms deemed clinically relevant (Saravanan, David, Bhugra, Prince, & Jacob, 2005).

#### Help-Seeking

Culturally competent providers must also be aware that help-seeking behaviours among migrant populations may differ from the patterns observed among Canadian-born patients. For instance, Western medicine may not be the preferred treatment for mental disorders, and many patients may be simultaneously seeking treatment from traditional health care providers (Alem, Jacobsson, Araya, Kebede, & Kullgren, 1999; Chiu, Ganesan, Clark, & Marrow, 2005; Neale & Wand, 2013; Saeed, Gater, Hussain, & Mubbashar, 2000). Because of deeply rooted cultural beliefs and stigmatization, many patients from cultural minority populations may also delay seeking mental health care services, and may be in crisis by the time they seek care (Donnelly et al., 2011; Gureje & Alem, 2000; Whyte, 1991). Patients may also delay help-seeking because of a lack of cultural recognition for mental illness (Sadavoy, Meier, & Ong, 2004; Teng, Blackmore, & Steward, 2007; Whyte, 1991). In many cultures, mental illnesses are seen as illegitimate in contrast to “real diseases,” which are physical; in these cases, patients may seek treatment for secondary physical symptoms while denying or ignoring symptoms of mental distress (Beiser & Fleming, 1986; Neale & Wand, 2013).

#### Diagnosis

Culture not only determines how individuals experience and exhibit illness; it also affects how health care providers interpret and diagnose the complaints of their patients.

Additionally, the undiscerning use of the Diagnostic and Statistical Manual of Mental Disorders (DSM) assumes that observations of upper-middle class European-American subjects can be generalized across cultures (Good, 1996; Jacob, 2014). This assumption, however, has been proven faulty by studies indicating high rates of misdiagnosis among migrant and minority populations (Bhui et al., 2001; Neighbors et al., 1989). Kleinman (1977) argues that because culture fundamentally affects how we conceive of and experience illness, culturally constructed categories of illness cannot be applied universally across different cultures.

In order to be culturally competent, providers must be aware of their own cultural biases and background, as well as of the Euro-American cultural constructions that undergird the DSM (Gone & Kirmayer, 2010). This is especially important in mental health care, as the diagnosis of mental disorders is largely an exercise in interpretation of the patient’s illness rather than performing a definitive diagnostic test (Jacob, 2014). Health care providers’ own culture plays a role in their interpretation of which behaviours are considered “normal” and which are “deviant.” In many cases, definitions of normality may vary cross-culturally and have important implications for the establishment of mutually acceptable treatment goals. For instance, in some cultures, communication with ancestors and hallucinatory experiences are not considered problematic, and are an important aspect of spiritual life (Bassey & Melluish, 2013). In a Euro-American culture, however, such phenomena might be interpreted as symptoms of psychosis (Bassey & Melluish, 2013; Qureshi et al., 2008). In these cases, spiritual practices that may be “normal” in a person’s culture may be medicalized, resulting in false diagnoses. On the other hand, sensations that are not often considered clinically significant among Euro-American patients may have important cultural meanings among members of other cultural groups, resulting in the under-diagnosis of depression and other mental disorders (Bhui et al., 2001). Providers must also be aware that cultures express emotions differently, and some patients may have negative perceptions of outward expression of emotion (Kirmayer, 2007b; Leavitt, 1996).

 Finally, the diagnosis of mental illness may not be easily accepted in some cultures. Patients whose cultures stigmatize or do not recognize mental disorders may be unsatisfied with the diagnosis, and psychological explanations for illness may be seen as an accusation of personal weakness (Kirmayer & Sartorius, 2007).

#### Treatment

 Mental health care providers are encouraged to adhere to evidence-based practice, which assumes that psychotherapeutic and medicinal treatments that have had positive treatment outcomes in clinical trials will be equally effective across all populations (Aisenberg, 2008; Alegria et al., 2010). However, the literature suggests that both medicinal treatments and Western psychotherapies may be ineffective (or even harmful) when used cross-culturally (Jones & Perlis, 2006; Lin, Poland, & Anderson, 1995; Lin, Smith, & Ortiz, 2001; Littlewood, 2001; Xu, 2009). Cultural competence is essential for negotiating a treatment plan that will be effective and will provide relief in accordance with the patient’s cultural model. Western therapeutic discourse is largely based on assumptions of what constitutes wellness and health; because these assumptions are derived from local cultural norms, they may inadvertently devalue alternate frames of reference or at the very least lead to ineffective treatment plans (Gaines, 1992; Kirmayer, 2007b; Littlewood, 2001).

While it is often presumed that all people are biologically the same, it is increasingly recognized that cross-cultural variations in biologies exist and may contribute to differences in patients’ response to medications (Lock, 1993; Xu, 2009). However, the samples used in clinical trials rarely reflect the ethnic and cultural composition of the general population; they consist largely of participants who are middle-class, educated, and who suffer from a single disorder (Aisenberg, 2008; Kirmayer, 2012a). This is problematic because cross-ethnic differences have been shown to affect both pharmacodynamics (how the drug is absorbed, distributed, metabolized, and excreted); and pharmacokinetics (how the drug interacts with receptors, and its cellular and physiological impacts) (Jones & Perlis, 2006; Lin et al., 2001). In the United States, adequate ethnic representation has been a requirement of federally-funded clinical trials since 1994; however, medications that were approved prior to 1994 were tested largely on homogeneous samples of white males (Xu, 2009).

In addition, studies measure outcomes in terms that fit the biomedical paradigm. While these outcome measures have value for Euro-American participants, they may have little significance cross-culturally (Kirmayer, 2012a). Cultural competence requires that providers both explore the outcomes desired by their patients as well as beliefs that their patients may hold about pharmacologic treatments. For instance, participants in a study of peri-natal depression and anxiety among migrant women by Neale and Wand (2013) expressed concern about doctors being too eager to prescribe medications and preferred practical and emotional support over medical management of their symptoms. Moreover, by encouraging providers to explore the impact of patients’ experiences and culture on their mental health, cultural competence also improves providers’ ability to treat the root of socio-emotive problems rather than using medicine-based solutions that are assumed to transcend context (Jacob, 2014).

 Psychotherapy may similarly have mixed results among patients from non-Western cultures. Both the methods involved in psychotherapy as well as the target outcomes may conflict with culturally mediated beliefs and values (Gone, 2008; Kirmayer, 2007b). The goals of psychotherapy are consistent with a Western, egocentric concept of the self; psychotherapy promotes individualism and encourages patients to express themselves rationally and with one voice (Kagitcibasi, 2005; Kirmayer, 2007b). Psychotherapy also often focuses on helping the patient to appreciate their individuality and uniqueness (Kirmayer, 2007b). For patients from sociocentric cultures that derive self-worth from their relationships with others and that consider family and community dynamics to be an integral part of the self, this individualistic perspective fundamentally alienates key elements of their concept of personhood (Kagitcibasi, 2005; Kirmayer, 2007b). Patients from sociocentric cultures may also expect treatment to involve the whole family, or members of their clan or community (Lo & Fung, 2003; Tseng, 1999). This is because treatment in such cultures often focuses on repairing relationships with others (Kirmayer, 2007b; Tseng, 1999).

Western psychotherapy also demands a willingness to discuss private feelings and experiences. However, in some cultures the expression of emotion may be interpreted as weakness or moral deficiency. In these encounters, providers who focus on what is said may miss important non-verbal or metaphoric messages (Kirmayer, 2007b). Moreover, the expression of emotion and the act of confessing may be harmful as they cause the patient to feel that they are disrupting social relations (Kirmayer, 2007b). Patients from non-egocentric cultures may also be at odds with the goal of gaining control over their surroundings (Weisz, Rothbaum, & Blackburn, 1984). In many cultures, power is derived from one’s ability to acquiesce and adjust to their surroundings rather than from their ability to dominate or control them (Kirmayer, 2007b; Weisz et al., 1984).

 Culturally competent psychotherapy demands that providers explore and understand the worldview and values of their patients, and that they negotiate appropriate treatment methods and goals (Lo & Fung, 2003; Tseng, 1999). Otherwise, psychotherapy threatens to be not only ineffective, but even harmful (Kirmayer, 2007b; Lo & Fung, 2003).

###  1.5.2. Building Culturally Competent Health Systems

While the focus of many training programs is to improve cultural competence at the clinical level, sociocultural barriers also exist at the other levels of health care systems. Cultural competence must therefore be achieved at the organizational, structural, and clinical levels (Betancourt et al., 2003; Browne et al., 2009; Vega & Rumbaut, 1991; Whealin & Ruzek, 2008). The organizational level of the health care system concerns the composition of the health care leadership and workforce, and the degree to which this composition is reflective of the general population (Betancourt et al., 2003). It also involves the other organizations involved in the provision of health care, and how well relevant community-based organizations are integrated into the health care system (Bhui et al., 2007). The structural level concerns the funding of health care and related services, as well as the bureaucracies that govern how individuals interact with health care services (Betancourt et al., 2003). Finally, the clinical level involves the interactions between individual patients and providers (Betancourt et al., 2003).

#### Organizational

In order to improve cultural competence at the organizational level, services must be implemented according to the needs of the consumers of that service (Bhui et al., 2007). Organizations that are culturally competent often work with other community groups in order to ascertain these needs; working with traditional healers, religious or spiritual leaders, and other community organizations can all lend to an organization’s ability to provide culturally competent care (Bhui et al., 2007).

 An additional factor that can contribute to health disparities is the racial/ethnic composition of the workforce and leadership of the health care system (Betancourt et al., 2003). By diversifying the leadership of the health care system, policies and procedures will be formulated in ways that consider a variety of social and cultural understandings of health and health care, and delivery systems may be more likely to meet the needs of minority populations (Betancourt et al., 2003). Diversity is also important in the health care workforce; studies have not only shown that racial concordance between patient and physician can lead to improved outcomes and patient satisfaction, but also that patients from minority groups often prefer receiving care from physicians from minority groups (Asanin & Wilson, 2008; Betancourt et al., 2003).

#### Structural

Cultural competence is also necessary at the structural level in order to address barriers to care that arise from complex bureaucracies and lack of funding. While wait times, poor referral mechanisms, and a lack of continuity of care are other examples of structural barriers that impact patients from low socioeconomic groups, these barriers disproportionately impact minority groups (Betancourt et al., 2003). Moreover, the lack of funding for interpretation services and the consequent language barriers that impede migrant access to health care result from cultural incompetence at this level (Betancourt et al., 2003). Newcomer patients’ access to health care services may also be obstructed by complex legislation that governs migrant health care and the economic consequences of these pieces of legislation (Asanin & Wilson, 2008; Oxman-Martinez et al., 2005). As health care is generally a provincial responsibility while immigration and settlement services are federal responsibilities, there is often a lack of coordination between government agencies in providing for the health and welfare of newcomers (McKeary & Newbold, 2010). In order to achieve cultural competence at the structural level, such bureaucratic barriers to health care must be addressed. For instance, waiting periods and the denial of public health insurance for certain classes of immigrants create barriers to accessing health care (Oxman-Martinez et al., 2005). Amidst recent cuts to the Interim Federal Health Plan (IFHP), which provides limited health insurance to refugees and refugee claimants, there is even greater confusion among both patients and providers and decreased access to key services, including psychological support services (Barnes, 2013; Canadian Council for Refugees, 2013). The IFHP now includes six different types of coverage; individuals’ coverage is dependent on the immigration category to which they belong (Citizenship and Immigration Canada, 2014 ). Although many government-assisted refugees continue to have access to the same services as under previous coverage, for the majority of refugees and refugee claimants, coverage has been drastically reduced or completely eliminated (Barnes, 2013). To receive even limited coverage, individuals must be aware of their entitlements, and must be able to complete the necessary paperwork to apply to IFHP, which can itself be a barrier (Barnes, 2013; Canadian Council for Refugees, 2013; McKeary & Newbold, 2010). Refugees must repeat the application process every twelve months or until they are eligible for provincial health insurance (Citizenship and Immigration Canada, 2014 ).

Without health coverage, the costs of either paying out of pocket for health care or procuring private insurance are often prohibitively high. This can often lead to the forgoing of treatment until a health crisis occurs or until the waiting period is over (Asanin & Wilson, 2008). Economic barriers to health also impede newcomer health as immigrants are disproportionately unemployed and are therefore less likely to have access to employer health insurance plans and coverage for prescription medication (Asanin & Wilson, 2008). The cuts to IFHP only worsen these barriers. Limiting IFHP funding to urgent or essential care reduces access to care in the early stages of illness, and virtually eliminates health promotion activities (Barnes, 2013).

Not only is the insurance coverage status of newcomers difficult to understand for migrant patients; health providers are also often unwilling to accept clients with such complex insurance plans (Edge & Newbold, 2013; McKeary & Newbold, 2010). The lack of access to individual physicians can often drive newcomers to disproportionately use walk-in clinics and emergency rooms, which are already overcrowded due to shortages of primary care providers (McKeary & Newbold, 2010). Evidence points to the shortage of primary care providers as a key barrier to newcomer health in Canada (Asanin & Wilson, 2008; McKeary & Newbold, 2010). Minority patients’ reliance on walk-in clinics and hospitals for primary care is a symptom of this shortage, which results in a lack of continuity of care and patient dissatisfaction (Asanin & Wilson, 2008; Donnelly et al., 2011).

The literature on newcomer experiences with the health care system extensively documents the impact of language barriers on newcomer access to health care; the lack of funding for medical interpretation services is a key structural barrier to immigrant health (Asanin & Wilson, 2008; Betancourt et al., 2003; Flores, 2005). Language barriers are a major challenge to the delivery of culturally competent care and can result in patient dissatisfaction, poor comprehension and compliance, and more frequent emergency room use (Betancourt et al., 2003; Komaric, Bedford, & van Driel, 2012). Without adequate interpretation services, patients for whom English is a second language may have trouble conveying health concerns as well as understanding medical directions and diagnoses (Asanin & Wilson, 2008; McKeary & Newbold, 2010). Additional time may be necessary to navigate language discordance between the patient and the provider (McKeary & Newbold, 2010; Newbold & Willinsky, 2009), contributing to the perception that appointments with primary care providers are rushed, impersonal, and incomprehensive (Asanin & Wilson, 2008). Moreover, language barriers pose an even greater barrier to accessing mental health care, where counselling, cognitive therapy, and community based health programs are often integral to treatment and communication between the physician and the patient is essential (Donnelly et al., 2011).

Despite evidence of the benefits of using trained interpreter services in health care settings (Flores, 2005; Hampers & McNulty, 2002; Kuo & Fagan, 1999), the shortage of services, lack of funding, and the absence of clinician training for working with interpreters continue to hinder cultural competence at the structural level (Flores, 2005). It is typically the responsibility of the patient or the community health centre to procure and pay for interpretation and translation services, either in person or through an expensive telephone message relay service (McKeary & Newbold, 2010). Moreover, due to the shortage of interpreters, client confidentiality may be compromised in small cultural communities (McKeary & Newbold, 2010). Finally, training is necessary in order to improve clinicians’ ability to work with interpreters and to educate clinicians on the importance of using medical interpreter services, especially as studies indicate that clinicians perceive interpreter services as unhelpful and a source of inefficiency (Flores, 2005; Kline, Acosta, Austin, & Johnson, 1980; Tocher & Larson, 1999).

It is important that the needs of newcomer populations are recognized in the formulation of health care budgets and that funds are allocated to services and training that improve cultural competence at the structural and clinical levels (McKeary & Newbold, 2010).

#### Clinical

Cultural competence at the clinical level exists when health care providers are aware of social and cultural factors that may influence the experiences of their patients (Beach et al., 2005; McKeary & Newbold, 2010). In order to achieve cultural competence at the clinical level, sociocultural differences between the physician and the patient must not only be recognized: they must be explored, understood, and appreciated. Reflexivity is a core component of cultural competence at the clinical level, as providers’ must explore the impact of their own ethnocultural identity on their experiences and the experiences of their patients (Anderson, 1998; Kirmayer, Fung, et al., 2011). Initiatives that promote clinical cultural competence aim to improve providers’ knowledge of the impact of sociocultural context on both their own health beliefs and behaviors and on those of their patients (Betancourt et al., 2003). Barriers that impede migrant health at the clinical level range from overt racism and discrimination to unwitting prejudice, ignorance, and stereotyping (Kirmayer, Fung, et al., 2011). Cultural incompetence at the clinical level reduces providers’ ability to provide accurate diagnoses (Bhui et al., 2001), establish a trusting therapeutic relationship (Beach et al., 2005), and take into account the influence of diverse social and cultural contexts on patients’ health beliefs and behaviours (Kirmayer, Fung, et al., 2011). Moreover, the perception of cultural incompetence discourages health care-seeking among migrant patients (Neale & Wand, 2013). This thesis focuses on the implementation of cultural competence at the clinical level, as it explores the experiences of mental health care providers.

# CHAPTER 2: LITERATURE REVIEW

## 2.1. TEACHING CULTURAL COMPETENCE

Several approaches have been used to train health care providers in cultural competence. Teaching methods vary from “categorical” to “cross-cultural,” or may include a combination of both (Betancourt et al., 2003). The former strategies rely heavily on increasing providers’ knowledge of specific cultures and the beliefs and behaviours of members of these cultural groups (Betancourt et al., 2003). However, these approaches have been criticized for conceptualizing cultural competence as a list of “do’s and don’ts” for providers and for promoting the use of stereotypes (Bassey & Melluish, 2013; Kleinman & Benson, 2006). This approach is often criticized for conflating culture with ethnicity, nationality, and language, and for essentializing culture in a way that defines how patients of a given ethnic background should be treated (Kleinman & Benson, 2006). Moreover, by essentializing cultures that are “different,” the categorical approach to teaching cultural competence engages in ‘Othering’ practices which magnify differences and reproduce positions of domination and subordination (Johnson et al., 2004). Rather than improving providers’ capacity to respond appropriately to diverse sociocultural realities, categorical training methods in effect teach health care providers to use stereotypical descriptions of ethnocultural groups in ways that ignore individuality and hinder the establishment of interpersonal relationships (Johnson et al., 2004). Unfortunately, because training in cultural competence has traditionally used this categorical approach, concerns about the assumptions that underlie such trainings have led to criticisms of training in cultural competence in general (Anderson, 1987; Betancourt et al., 2003; Kleinman & Benson, 2006; Pon, 2009).

 However, training in cultural competence has increasingly focused on cross-cultural learning. In comparison to the categorical approach, cross-cultural training methods focus more on encouraging reflexivity among providers and instilling an awareness of cultural and social influences on health beliefs (Betancourt et al., 2003). The cross-cultural approach also focuses on teaching skills to improve communication and providers’ ability to respond to diverse needs (Betancourt et al., 2003). A reflexive exploration of ideologies that shape health care practices is a critical component of cross-cultural training methods (Anderson, Blue, & Lau, 1991). This reflexivity lends to providers’ ability to recognize and negotiate different understandings of health and illness in a culturally sensitive way (Anderson et al., 1991).

### 2.1.1. Curriculum

 A review of the literature suggests that in general, cultural competence training addresses three components: knowledge, skills, and attitudes (Bassey & Melluish, 2013; Beach et al., 2005; Betancourt et al., 2003; Bussema, 2006; Carter et al., 2006; Qureshi et al., 2008). By targeting these three broad areas, cultural competence training aims to equip providers with a knowledge base, the skills that enable the application of this knowledge in practice, and an awareness that leads to a questioning of preconceived attitudes and beliefs about health and illness (Qureshi et al., 2008). Although there is no gold standard for teaching cultural competence, most recent training methods address these categories and have similar educational goals (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Bassey & Melluish, 2013; Beach et al., 2005; Betancourt et al., 2003; Bhui et al., 2007; Kirmayer, 2012a; Kirmayer, Fung, et al., 2011; Qureshi & Collazos, 2005; Qureshi et al., 2008).

#### Knowledge

The knowledge included in cultural competence training programs varies, but may include a range of information, including broad definitions of key terms, such as culture, race, and ethnicity, as well as more specific information about culture’s influence on health care beliefs and experiences (Anderson et al., 2003; Qureshi et al., 2008). In general, the knowledge component of training in cultural competence aims to provide health care professionals with a transcultural knowledge base (Qureshi et al., 2008). Rather than focusing on the characteristics of specific cultural groups, transcultural knowledge consists of more general information, such as variations in communication styles and expressiveness, or different types of explanatory models. This knowledge base allows for a greater understanding of how explanations of illness and expressions of distress vary across cultures and an awareness that health-related beliefs and values are not universal (Bassey & Melluish, 2013; Beach et al., 2005; Bhui et al., 2001). General knowledge of race, culture, ethnicity, and power is intended to be relevant to all cross-cultural encounters (Bassey & Melluish, 2013; Beach et al., 2005) Culturally competent providers are also aware of the barriers facing members of non-dominant cultural groups and the societal inequities that affect patients’ lives and may contribute to their health status (APA, 2002; Collins & Arthur, 2007; Daniel, Roysircar, Abeles, & Boyd, 2004).

While knowledge about specific cultural groups is not intended to supersede individuality and should not promote stereotypes, information about cultural groups can be useful for the provision of culturally competent care (Bassey & Melluish, 2013). Many training guidelines also suggest that health care providers obtain supplemental knowledge about the beliefs, practices, help-seeking behaviours and disease burden among the cultural groups to whom they provide care (Bassey & Melluish, 2013; Betancourt et al., 2003; Kirmayer, Fung, et al., 2011). Providers are better positioned to provide appropriate care when they have the knowledge necessary to contextualize patients’ experiences. Knowledge of family and community structures and functions enables providers to understand the context in which patients experience both illness and treatment as well as specific constraints and opportunities inherent to their roles in society and culture (Bhui et al., 2007; Kirmayer, 2012a). In addition, cultural competence involves having knowledge about social justice issues, such as power relations and the impact of colonization (Kumagai & Lypson, 2009). Knowledge of the experiences of immigration, acculturative stress, racism, and discrimination also allows providers to contextualize the experiences of their patients and avoid medicalizing normal stress responses (Edge & Newbold, 2013; Qureshi et al., 2008). By educating providers about relevant community resources, cultural competence training can also help providers connect patients with support structures that can help with dealing with these stresses (Kirmayer, Narasiah, et al., 2011).

Understanding the effect of religion on health-related behaviours (such as fasting) may provide important insight into patient illness and experience (Komaric et al., 2012). Knowledge of community explanations of illness and treatment variations can also be included, and may help providers understand the experiences of their patients (Beach et al., 2005; Bhui et al., 2007; Moffic & Kinzie, 1996). By improving providers’ knowledge of alternative interventions, they may be better equipped to achieve goals that are consistent with client needs and expectations (Bassey & Melluish, 2013).

#### Skills

The “skills” component of cultural competence training is essential because it aims largely to provide health care professionals with the ability to apply their awareness and knowledge of culture to their relationships and practice in an appropriate and effective way (Bassey & Melluish, 2013). The skills included in curricula often reflect the idea that culturally competent health care meets the needs of the patient, and focus on improving cross-cultural communication, building therapeutic relationships, and reaching a shared understanding that translates into flexible and mutually acceptable treatment plans (Bassey & Melluish, 2013; Beach et al., 2005; Qureshi & Collazos, 2005).

 Intercultural communication skills are relevant regardless of whether or not the provider and patient speak the same language. Communication involves both verbal and non-verbal signals; cultural difference can affect both the patient and the providers’ interpretation of what is being communicated (Qureshi et al., 2008; Singh, McKay, & Singh, 1998). For instance, the meanings of gestures, eye contact, and other non-verbal cues may be culture-bound and can be interpreted differently (Singh et al., 1998). Cultural competence training can aid providers in interpreting non-verbal cues and in being aware that their first impression of these cues may not be applicable. Cultural competence involves explicit attention to language use even where the patient and provider speak the same language. Words may also evoke different psychological associations, and attention must be paid to the values embedded in language (Bassey & Melluish, 2013; Leong, 1997; Tseng, 2004). Training in cultural competence may teach providers when to pay attention to language-use and how to explore what patients mean (Bassey & Melluish, 2013). Providers must be able to identify and negotiate different styles of communication (Betancourt et al., 2003). By teaching providers to practice “language independence,” or the ability to accommodate their communication style to their patients’ linguistic and cultural needs, cultural competence training improves providers’ ability to communicate meaningfully with their patients (Lo & Fung, 2003; Qureshi et al., 2008; Tseng, 2004; Van Wieringen, Harmsen, & Bruijnzeels, 2002). For instance, Tseng (2004) suggests that providers can use culturally rooted metaphors when speaking to their patients in order to make information easier to understand.

 When the patient and provider are unable to communicate in the same language, the use of a professional medical interpreter is an important but underused practice (Diamond, Schenker, Curry, Bradley, & Fernandez, 2009; Kirmayer, Fung, et al., 2011; Tribe & Lane, 2009). Cultural competence training not only teaches providers about the importance of using an interpreter; it also helps develop skills that are essential for working through an interpreter, including clear speech and thoughtfulness with regards to the use of language (Kirmayer, Fung, et al., 2011; Tribe, 2009; Tribe & Lane, 2009). Other skills related to intercultural communication include the use of short sentences, repetition, and alternate language, as well as frequent verification of patient comprehension (Rosenberg, Richard, Marie-Thérèse, & Abdool, 2006). Research has also indicated that providers may benefit from training in recognizing situations in which the use of a professional interpreter is necessary (Diamond et al., 2009). Improving providers’ skills in working with interpreters may improve the quality of the communication between provider and patient, and may also increase providers’ confidence in working with interpreters and the likelihood that professional interpreters will be used (Tribe, 2009). However, structural barriers, such as the lack of funding for interpretation services, may continue to hinder the widespread utilization of professional medical interpreters (McKeary & Newbold, 2010).

 The second key set of skills revolves around building the therapeutic relationship through provider credibility and empathic understanding (Bassey & Melluish, 2013). The therapeutic relationship, or the bond between the provider and patient, is directly related to patient adherence and positive outcomes (Qureshi et al., 2008). Positive therapeutic relationships are established only when there is sufficient trust and perceived similarity between the provider and patient’s goals. Different explanatory models and expectations for social norms and relations may have a detrimental effect on the therapeutic relationship, and therefore on patient outcomes (Qureshi et al., 2008). Cultural competence training can improve providers’ ability to adjust their communication and intervention styles. An exploration of client’s expectations for the therapeutic relationship may be undertaken based on knowledge of cultural norms and power-dynamics (Bassey & Melluish, 2013). For instance, some clients may prefer that practitioners act authoritatively while others prefer a more familiar relationship; a failure to meet the client’s expectation for the therapeutic relationship may reduce provider credibility and prevent the patient from trusting and adhering to the provider’s treatment plan (Bassey & Melluish, 2013; Sue & Zane, 2009; Tseng, 2004). In cross-cultural relationships, the provider’s credibility (and therefore the therapeutic relationship) is often threatened by a lack of congruence between the provider and the patient’s conceptualization of the problem, culturally incompatible treatment plans, and differing treatment goals (Sue & Zane, 2009). Training in cultural competence may facilitate the therapeutic relationship by teaching providers to deal with discrepancies in perspective either by demonstrating the validity of their perspective or by accommodating the patient’s perspective when possible (Sue & Zane, 2009).

 Several authors stress the importance of empathic understanding for building a positive therapeutic relationship (Bassey & Melluish, 2013; Farnill, Todisco, C., & Bartlett, 1997; Sue & Zane, 2009). Providers can demonstrate empathic understanding by recognizing and acknowledging ignorance about the patient’s culture, asking for clarification about the use of linguistic elements, and expressing a desire to understand the patient’s experiences and learn about their culture (Alberta & Wood, 2008; Bassey & Melluish, 2013; Pedersen, 2001; Sue, 1998). Some authors advocate the use of the “ethnographic approach” to develop an empathic understanding (Alberta & Wood, 2008). By taking this approach, providers are meant to “learn from people” rather than “study people”, and come to understand how patients perceive and experience their illness and treatment (Alberta & Wood, 2008; Kleinman & Benson, 2006). The ethnographic approach aims to dispel the notion that culture is a set of determined traits, and is sometimes proposed as an alternative to cultural competence (Kleinman & Benson, 2006). Once the provider discerns different beliefs related to health and illness, he or she must reflect on their own values and attitudes in order to identify and challenge biases and pre-assumptions that may be detrimental to the therapeutic relationship (Donnelly, 2002; Kleinman, 1978; Weerasinghe & Mitchell, 2007)

 Finally, the skills taught in cultural competence training aim to enable the development of a shared understanding of patients’ experiences and goals. When a shared understanding is reached, providers are better equipped to effectively and respectfully communicate with their patients (Alberta & Wood, 2008). In order to reach a shared understanding, providers must acquire the skills necessary to acknowledge and accept alternative worldviews and interpretations of illness and medical phenomena.

 Providers must be sufficiently skilled in conducting a cultural history. Providers should gather culturally and socio-politically relevant information about the client in order to better understand their experience and their understanding of their illness (Collins & Arthur, 2007). Cultural factors may influence patients’ motivation and willingness to seek treatment, their compliance with treatment, and the support networks that are available to them (APA, 2002). In order to accommodate multiple divergent explanatory models, providers must be skilled in diunital reasoning, or the ability to accept other cultural beliefs as valid; the integration of different worldviews; the use of scientific-mindedness, or the testing of hypotheses; and in dynamic-sizing, or knowing when to generalize and when to be exclusive (Alberta & Wood, 2008; Leong, 1997; Sue, 1998).

 Diunital reasoning involves suspending judgment of a cultural practice. This is a critical skill for providers in cross-cultural encounters because it not only allows for the acknowledgment and appreciation of alternate explanatory models, but it also allows providers to do so while maintaining their own views. By considering a practice separately from personal feelings, providers are better equipped to understand unfamiliar concepts and practices (Alberta & Wood, 2008). Alberta and Wood (2008) provide a concise explanation of diunital reasoning:

“Diunital reasoning begins with acknowledgement of the possibility that the culturally grounded views of others may have validity, progresses through acceptance of these other interpretations of the world as valid and legitimate representations of the experiences of other cultural groups, and finally comes to fully recognize these accounts as reasonable and accurate accounts of the experience of another cultural group. In its most robust form, diunital reasoning allows one to accept as true two mutually exclusive concepts,” (p.569).

Diunital reasoning is essential for the development of a shared understanding because it allows the provider to balance the legitimacy of their own worldview with the perspective of their patient. By accepting the validity of the patient’s experience, providers are better equipped to respond to the patient’s needs and adopt solutions that are culturally compatible. Because diunital reasoning does not require the abandonment of the provider’s worldview, this skill enables the provider to flexibly navigate between two cultural perspectives and integrate the patient’s perspective with their own (Alberta & Wood, 2008; Bassey & Melluish, 2013). This can result in a shared understanding in which both the patient and the provider’s perspectives are accommodated (Bassey & Melluish, 2013).

 The integration of different worldviews and perceptions requires that the provider discern whether their perception and that of their patient are functionally or conceptually equivalent. When two phenomena have the same function across cultures, they are said to be functionally equivalent; similarly, when two concepts are the same across cultures, they are said to be conceptually equivalent (Leong, 1997). An example of a concept that is not conceptually equivalent across cultures is the mind-body distinction that is pervasive in Western medical culture. Due to this lack of conceptual equivalence, it may be difficult to treat mental disorders among patients for whom the mind is not separate from the body and whose treatment goals and expectations may therefore differ significantly (Bassey & Melluish, 2013). Discerning functional and conceptual equivalence helps the provider to make sense of the patient’s worldview and is important for creating treatment plans that accommodate multiple perspectives. This skill is related to intercultural communication skills, as it requires that the provider explore meanings associated with client’s verbal and nonverbal communication. The provider is then able to mediate between different perspectives and negotiate a treatment plan that makes sense to the patient. Kleinman et al. (2006) describe the provider’s role in the mediation process as that of a “therapeutic ally” who understands the patient’s belief and, unless necessary, accommodates it rather than trying to change it.

 Scientific-mindedness and dynamic sizing are two skills that ensure that providers’ knowledge is applied responsibly and appropriately (Sue, 1998). Scientific-mindedness involves testing hypotheses rather than making assumptions based on patients’ culture (Bassey & Melluish, 2013). Providers are encouraged to consult knowledgeable community professionals about how phenomena are experienced within the cultural group and assess the relevance of cultural factors in each individual’s situation (Bassey & Melluish, 2013). Similarly, dynamic sizing is a skill used to determine when generalizations are appropriate and when to individualize and be exclusive. Dynamic sizing allows providers to balance between using stereotypes and ignoring group characteristics in order to appropriately contextualize patients’ experiences (Sue, 1998). In addition, dynamic sizing allows providers to identify common experiences that can be used to understand their worldview or feelings (Sue, 1998). Dynamic sizing also contributes to providers’ ability to recognize that each individual is unique while also encouraging culturally-tailored interventions (Komaric et al., 2012).

#### Attitudes

The third component of cultural competence training, attitudinal competence, is essential for the effective application of cultural knowledge and skills. Evidence suggests that inequality in health care is largely a result of prejudice and racism; awareness of such attitudes and perceptions is critical for improving outcomes among migrant and minority patients (Ontario Federation of Community Mental Health and Addiction Programs, 2009; Qureshi et al., 2008). The frustration of dealing with cultural and linguistic barriers can translate into intolerance among some providers, resulting in shorter appointments that fail to engage the patient in his or her own care (Diamond et al., 2009; Ontario Federation of Community Mental Health and Addiction Programs, 2009). Attitudinal competence teaches providers to be aware of their own cultural heritage and of any prejudices they may hold, and promotes an appreciation and respect for other cultures (Sue, Arredondo, & McDavis, 1992). Reflection on one’s own worldview and the cultural factors that influence one’s perspective is taught as a lifelong process that contributes to cultural competence (Bassey & Melluish, 2013; Sue et al., 1992). Training in cultural competence encourages providers to continually question their assumptions and consider how their experiences have been constructed by sociocultural factors (Bassey & Melluish, 2013; Sue et al., 1992). By recognizing how they are influenced (and perhaps privileged) by culture, providers are better able to analyze how they come to understand and interpret patients’ experiences (Collins & Arthur, 2007). Unexamined cultural assumptions, prejudices, and ethnocentric perspectives can be barriers to the therapeutic relationship (Collins & Arthur, 2007). In addition, the providers’ acceptance of cultural influences on health and health behaviours enables a greater understanding of why knowledge about culture is relevant to the provision of health care (Pedersen, 2001).

 Attitudinal competence involves not only the recognition or tolerance of cultural differences; providers who are culturally competent must appreciate diversity and cease viewing themselves as “normal” in relation to “others” from different cultures (Collins & Arthur, 2007). Attitudinal competence involves actively seeking to consider cultural influences and a desire to further the development of cultural competence (Hutnik & Gregory, 2008). Training in cultural competence also encourages providers to become interested in learning about patient and family backgrounds, as well as about the broader sociopolitical-cultural context in which they and their patients exist (Anderson, 1987; Beach et al., 2005). The recognition that, like their patients, providers themselves are cultural beings who are influenced (and/or privileged) by virtue of culture, ethnicity, race, and linguistic ability is crucial in enabling the provider to provide respectful and non-judgmental care.

The attitudinal component of cultural competence training addresses some key criticisms of cultural competence, such as a lack of reflexivity and the arrogance of assuming that culture can be mastered (Anderson, 1987; Kleinman & Benson, 2006). Attitudinal competence, however, involves an ongoing process of self-reflection and a recognition and appreciation for culture as a dynamic phenomenon that shapes individuals’ experience.

### 2.1.2. Other Frameworks for Cross-Cultural Health Care

Many different terms are used to refer to aspects of cross-cultural health care education. While some terms may overlap, each has a unique definition. The lack of consensus about how to approach cultural differences is evident from the variation in definitions and use of each of these terms; some authors may present these approaches as alternatives to cultural competence, while others include them as a part of the cultural competence curriculum. The present section aims to define each of these terms and briefly explain how they are used in the literature on cultural competence. Figure 1 situates these concepts in relation to each other, demonstrating the overlap between certain concepts and the degree to which political considerations are considered salient.

Less political More political

#### Cultural sensitivity

Cultural sensitivity is sometimes portrayed as the first step towards cultural competence or cultural safety (Kirmayer, 2012b; NAHO, 2008; Whaley, 2008). Cultural sensitivity involves respecting and attempting to understand culturally-influenced perspectives of individual patients (Azad, Power, Dollin, & Chery, 2002; Kirmayer, 2012b). However, the ultimate goal of cultural sensitivity is to have patients comply with Western medical practices (Anderson, 1998). Cultural sensitivity also focuses strongly on encouraging providers to be respectful of different perspectives, rather than on encouraging an exploration and acceptance of these differences (Hutnik & Gregory, 2008). While cultural sensitivity is different from cultural competence, cultural humility, cultural safety, and other related terms, it is sometimes erroneously used as a broad descriptor for any educational programs related to the provision of multicultural care (Azad et al., 2002; Whaley, 2008).

#### Cultural humility

Cultural humility can be presented either as an alternative to cultural competence or as a part of the attitudinal component of cultural competence training (Gustafson & Reitmanova, 2010; Kirmayer, 2012b; Qureshi et al., 2008; Reitmanova, 2011; Tervalon & Murray-García, 1998). Cultural humility involves an awareness of the fact that culture can never be mastered; because cultures are dynamic and heterogeneous, cultural competence involves a commitment lifelong cultural learning (Qureshi et al., 2008; Tervalon & Murray-García, 1998). Cultural humility emphasizes that providers have only limited access to insider cultural knowledge and must respect the cultural dimensions of each patient’s experiences and understanding (Kirmayer, 2012b; Tervalon & Murray-García, 1998). Qureshi et al. (2008) present cultural humility as an awareness of the limitations of cultural competence, and as a component of attitudinal competence rather than as an alternative. In this context, cultural humility is a reminder that cultural competence is an ideal that cannot fully be reached and prevents providers from becoming over-confident in their ability to provide cross-cultural care (Qureshi et al., 2008). In contrast, Tervalon and Murray-García (1998) conceptualize cultural humility and cultural competence as two separate and distinct training outcomes in multicultural education. In this understanding of cultural humility, the idea that one can become “competent” in culture represents an arrogance that cannot be reconciled with the principles of cultural humility, which encourage flexibility and humbleness among providers (Tervalon & Murray-García, 1998).

#### Cultural safety

 Cultural safety is a distinct approach to analyzing power imbalances inherent in provider-patient relationships. Cultural safety is unique in that it was developed by nursing students who belonged to a non-dominant cultural group, the indigenous Maori of New Zealand (NAHO, 2006). Cultural safety is explicitly political; it is designed to draw attention to circumstances that reproduce inequality and power imbalances and emphasizes the role of power differentials in clinical encounters involving members of dominant and subdominant groups (Kirmayer, 2012b; Kirmayer, Fung, et al., 2011; Smye, Josewski, & Kendall, 2010). Rather than focusing on specific cultural groups, cultural safety highlights the importance of institutional discrimination, colonization, and colonial relationships (NAHO, 2008). Based on the idea that categorizing peoples can predetermine subject positions, cultural safety focuses on knowledge of race relations rather than knowledge of cultures (Browne et al., 2009; Papps & Ramsden, 1996). Additionally, cultural safety purports that it is the responsibility of health care institutions to address structural violence and inequality in a way that ensures that clinical encounters are not demeaning, disempowering, or otherwise culturally unsafe (Kirmayer, 2012b).

While some authors present cultural safety as an alternative to cultural competence and contrast the broad and political approach taken by cultural safety against the specific and scientific approach of cultural competence, others include cultural safety as an aspect or an outcome of cultural competence (Kirmayer, 2012b; NAHO, 2008). Cultural safety is officially endorsed by the Assembly of First Nations in Canada and by the National Aboriginal Health Organization (NAHO) as a means of improving the health status of First Nations, Inuit, and Métis in Canada; however, NAHO (2008) also supports cultural competence and defines cultural safety as an outcome of culturally competent care (Smye et al., 2010).

In addition, cultural safety overlaps with cultural sensitivity in teaching providers to be open-minded and respectful of other cultures (NAHO, 2008). Cultural safety also teaches providers to reflect on their own beliefs and attitudes, which is a component of attitudinal cultural competence (Bassey & Melluish, 2013; Crampton, Dowell, Parkin, & Thompson, 2003). Cultural safety is distinguished by the focus on structural and organizational issues, which helps to ensure that providers do not blame victims of historical and social processes for their current circumstances (Crampton et al., 2003; Kirmayer, Fung, et al., 2011). However, training in cultural competence should also give providers an awareness of sociopolitical, economic, and historic circumstances that contextualize patients’ experiences (APA, 2002; Collins & Arthur, 2007; Daniel et al., 2004).

#### Cultural formulation

The cultural formulation model is a tool included in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) that aims to help mental health care providers to obtain and organize cultural information through semi-structured interviews (Kirmayer, Fung, et al., 2011). The goal of introducing the cultural formulation model was to make the DSM more culturally sensitive; as such, there is significant overlap between the two concepts (Fortuna, Porche, & Alegria, 2009). However, cultural sensitivity is an outcome where cultural formulation can be more accurately described as a tool.

#### Critical culturalism

 Approaches to teaching cross-cultural health care in undergraduate curricula can be categorized as using the cultural competence model or as using the critical culturalism model (Gustafson & Reitmanova, 2010). In contrast to cultural competence, critical culturalism focuses on understanding the institutions and power relations that perpetuate health disparity. Critical culturalism also extends to groups beyond ethnic, religious, and racial minorities to people who belong to other marginalized social groups. The critical cultural approach focuses less on ascertaining information about patients’ health beliefs, and instead encourages a patient-focused interviewing style, in which patient perspectives and agenda are valued (Gustafson & Reitmanova, 2010; Reitmanova, 2011; Tervalon & Murray-García, 1998) The critical cultural approach to health care emerged largely in response to the perception that cultural competence takes a categorical approach to understanding culture and is a finite endeavor rather than an ongoing process. However, many descriptions of cultural competence include reflexivity and promote an understanding of sociopolitical and historic circumstances that perpetuate inequality and power relations. Moreover, while Reitmanova (2011) states that cultural awareness, cultural expertise, and cultural sensitivity are components of the cultural competence model while cultural responsiveness, cultural humility, anti-racist pedagogy, insurgent multiculturalism, cultural efficacy, and critical consciousness are components of the critical culturalism model, some descriptions of cultural competence include cultural humility, cultural responsiveness, and attention to power differentials (Bassey & Melluish, 2013; Kirmayer, Fung, et al., 2011; Qureshi et al., 2008). As such, this may be a somewhat false dichotomy.

## 2.2. IMPLEMENTATION OF CULTURAL COMPETENCE IN CANADA

 Although the framework of cultural competence has existed for forty years, it is only within the last two decades that associations involved in medical training have mandated multicultural education (Gustafson & Reitmanova, 2010; Kumagai & Lypson, 2009; Liaison Committee on Medical Education, 2014).

 In 1995, the World Health Organization’s report *Defining and measuring the social accountability of medical schools* outlined medical schools’ obligation to meet the shifting needs of a changing population (Boelen & Heck, 1995). The report emphasized the need for medical graduates to be sensitive to the needs of their community, including ethnic and racial minority populations (Boelen & Heck, 1995). In response, Health Canada developed a set of principles related to social accountability by which Canadian medical schools should abide (Dogra, Reitmanova, & Carter-Pokras, 2010; Health Canada, 2001). Health Canada’s report emphasized the need for medical schools to be aware of and responsive to the changing needs of their community (Health Canada, 2001). Shortly after, the Liaison Committee on Medical Education (LCME), which is responsible for the accreditation of medical education programs in the United States and Canada, mandated that all accredited medical schools include some form of cultural diversity education (Dogra et al., 2010; Liaison Committee on Medical Education, 2014). However, the language in these documents and reports is vague. Consequently, medical schools vary in their definition of culture and in their implementation of multicultural education programs (Azad et al., 2002; Dogra et al., 2010; Flores, Gee, & Kastner, 2000; Frank & MacLeod, 2005; Gustafson & Reitmanova, 2010; Kumagai & Lypson, 2009; Reitmanova, 2011). While physicians, nurses, and other health professionals may receive some training related to culture and diversity, the scope, duration, and framework of training methods vary significantly between programs (Betancourt et al., 2003; Dogra et al., 2010; Gustafson & Reitmanova, 2010; Reitmanova & Gustafson, 2009). For instance, in an overview of cultural education in Canadian medical schools, Dogra et al. (2010) found that while the majority of schools include cultural diversity training as curricular add-on (many lasting only a few hours), some incorporate diversity education throughout their entire undergraduate curricula. Many programs focus on the impact of cultural beliefs and health practices of minority populations, while others reflect more critically on health inequities and social injustice (Dogra et al., 2010). Moreover, there is little documentation of available continuing health care education related to cultural competence; consequently, it is difficult to discern whether professionals who graduated prior to the incorporation of cultural competence have access to relevant training.

 Under the LCME guidelines, Canadian medical schools’ curricula must include information about basic principles of cultural competence, cultural beliefs related to illness and health, and health disparity (Liaison Committee on Medical Education, 2014). However, there are no requirements as to which framework to use, or with regard to the number of course hours that must be dedicated to multicultural education. Gustafson and Reitmanova (2010) reviewed the websites of Canadian medical schools and found that a typical curriculum includes one or more learning objectives related to multiculturalism within a required course, and offers one or more optional courses related to cultural diversity. While some schools offered multicultural education over the course of all years of study, several of these curricula were much more limited in their approaches to diversity education and did not support these learning objectives with community-based opportunities (Gustafson & Reitmanova, 2010). A later study by the one of the same authors also found that many of the latter schools spend only a few hours covering issues related to multiculturalism and diversity (Reitmanova, 2011).

Approaching multiculturalism as an “add-on”, or as a topic appropriate for discussion in the form of a half-day workshop, has been criticized for perpetuating stereotypes (Frank & MacLeod, 2005). By oversimplifying issues related to culture and diversity, workshops like this omit important and complex issues related to social justice and racism; they often focus instead on emphasizing cultural differences (Frank & MacLeod, 2005; Kumagai & Lypson, 2009). Beach et al. (2005) reviewed thirty-four studies of health care provider education programs, and found that only two mentioned concepts related to social justice, such as racism and discrimination. The authors postulate that the failure to emphasize the importance of reflexivity increases the likelihood of stereotyping behaviours and bias on the part of the provider (Beach et al., 2005).

During the 1990s, numerous tools and guidelines were developed to promote cultural competence in mental health. In 1990, the APA published the Guidelines for Providers of Psychological Services to Ethnic, Linguistic and Culturally Diverse Populations (APA, 2002). In the same year, the Canadian Psychological Association published a revised code of ethics; the second principle, “responsible caring,” now explicitly addressed the importance of reflexivity on the part of the provider with regard to the influence of their own culture (Canadian Psychological Association, 1991). However, educational strategies are similarly mixed, and little has been written about continuing education in cultural competence for practicing psychologists (Bussema, 2006; Delphin & Rowe, 2008). The DSM-IV was released in 1994 and explicitly included cultural concerns in a way that had not previously been the case (Good, 1996). For instance, Appendix IX of the DSM-IV is the Outline for Cultural Formulation, which can be used to help the provider in eliciting patients’ explanatory models and cultural values and beliefs (APA, 1994; Fortuna et al., 2009; Good, 1996). The DSM-5, the most recent iteration of the DSM, includes an entire section on culture, in which it is argued that all facets of the illness experience, including idioms of distress, support systems, and help-seeking behaviours, are culturally-mediated (APA, 2013; Jacob, 2014). These modifications to the DSM increase the likelihood of the manual being used in a culturally competent way rather than being rigidly applied across cultures.

## 2.3. HISTORY & EVOLUTION OF CULTURAL COMPETENCE

Although the paradigm of cultural competence has emerged only in the last thirty years, the link between culture and psychiatry has been recognized (and exploited) for over a century (Kirmayer, 2012b; Moffic & Kinzie, 1996). In his work *Primitive Mentality,* Lévy-Bruhl (1923) contrasted European explanatory models of illness to those of “primitives” in order to demonstrate the ignorance of non-Europeans:

“The fact is that the primitive, whether he be an African or any other, never troubles to inquire into causal connections which are not self-evident, but straightway refers them to a mystic power […] If primitives do not think of seeking causal connections, if, when they do perceive them or have them pointed out, they consider them as of slight importance, it is the natural consequence of the well-established fact that their collective representations immediately evoke the instrumentality of mystic powers. It follows that the causal connections which, to us, are the very framework of Nature, the basis of its reality and stability, are of very little interest in their eyes.” (p.36-37).

Although the above quotation is far from the attitudes promoted by cultural competence, it demonstrates an early recognition of culture’s influence on understandings and experiences of illness. Such writings were used to justify the colonial project and the resulting inequalities and underdevelopment (Kirmayer, 2007a).

 The observations of physicians during each of the two World Wars contributed to recognition of the role of culture in health. For instance, Benton (1921) noted the high prevalence of “war neurosis” among foreign (i.e. Italian and East-European) veterans after the First World War (Benton, 1921; Moffic & Kinzie, 1996). During the Second World War, physicians found that anti-malarial treatments of primaquine caused hemolysis, or a rupturing of the red blood cells, among African American patients (Carson, Flanagan, Ickes, & Alving, 1956; Jones & Perlis, 2006). In a subsequent study, Carson et al. (1956) found that African American patients were more likely to experience hemolysis, or the premature breaking down of red blood cells, when taking the drug primaquine. They established that this was because African Americans are more likely to be deficient in an enzyme that is particularly important for the function of red blood cells. Their study was a precursor to the field of pharmacogenetics, which is an important component of cultural competence as health care providers should have some knowledge of how pharmaceuticals can affect patients differently (Jones & Perlis, 2006; Lin et al., 1995).

 Transcultural psychiatry, a predecessor to ethnopsychiatry and cultural competence, emerged soon after (Kalanga & Tshisekedi, 2008). Transcultural psychiatry emphasized cross-cultural differences in the prevalence of mental disorders, differences in behaviours, and culturally-specific syndromes (Kalanga & Tshisekedi, 2008). While culture-bound phenomena are now criticized as a practice of pathologising cultural beliefs and behaviours, transcultural psychiatry led to the recognition that traditional healing methods were often more effective than Western psychotherapy (Bains, 2005; Bhui, 1999). The negotiation of treatment plans that are congruent with patients’ cultural beliefs is a practice that emerged from transcultural psychiatry; it is now a core skill taught in cultural competence training (Bains, 2005).

 Today’s writings on cultural competence also emphasize the importance of providers’ awareness of the impact of social structures on health disparities. In one early analysis of the impact of social issues on mental health, Frantz Fanon (1952) wrote about the impact of colonialism and racism on the mental health of colonized people. In describing the case of a black patient who desires to be white, he wrote,

“If he is overwhelmed to such a degree by the wish to be white, it is because he lives in a society that makes his inferiority complex possible, in a society that derives its stability from the perpetuation of this complex, in a society that proclaims the superiority of one race; to the identical degree to which that society creates difficulties for him, he will find himself in a neurotic situation. […] As a psychoanalyst, I should help my patient to become *conscious* of his unconscious and abandon his attempts at hallucinatory whitening, but also to act in the direction of a change in the social structure” (p.76).

Fanon (1952) wrote of his responsibility to invoke social changes. Cultural competence training similarly encourages providers to advocate for their patients. In the context of the civil rights movement, the impact of racism and discrimination on black Americans’ mental health served as an important case study of the impact of social issues on psychotic symptoms (Derbyshire & Brody, 1964; Moffic & Kinzie, 1996). Studies of marginality and the mental health of black Americans shone a spotlight on the interaction of social, cultural, and psychological determinants of health; adequate consideration of these factors continues to be crucial to the provision of culturally competent care (Derbyshire & Brody, 1964).

 The civil rights movement also provided an opportunity for the emergence of the community health movement, which stressed the importance of providing health care services that are responsive to cultural differences and the needs of minority ethnic groups (Chin, 2000; Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2003). The concept of cultural sensitivity emerged in recognition of the racial and economic barriers faced by black Americans, and of the language and cultural barriers faced by immigrants, who increasingly migrated from countries that were non-European, non-white, and non-English-speaking (Chin, 2000). The concept became more widely accepted as the influx of Indochinese refugees after the fall of Saigon in 1975 prompted the establishment of specialty psychiatric clinics and therapy groups to provide culturally sensitive care (Kinzie et al., 1988; Moffic & Kinzie, 1996; Westermeyer, Vang, & Neider, 1983). In 1974, the incorporation of cultural diversity education in training programs for psychologists was endorsed at the National Conference on Levels and Patterns of Professional Training in Psychology, held in Vail, Colorado (Korman, 1974). However, the American Psychological Association did not include cultural diversity education in their accreditation standards for effective training until 1986 (APA, 2002).

 Towards the end of the 1970s, transcultural psychiatry was replaced by ethnopsychiatry and the “new cross-cultural psychiatry” (Kalanga & Tshisekedi, 2008; Kirmayer, 2006; Kleinman, 1977). In his influential paper, “Depression, Somatization and the ‘New Cross-Cultural Psychiatry,’” Kleinman (1977) eschewed the notion that culture influences symptoms but that diseases are the product of biologically universal processes; he argued instead that definitions of mental disorders are culturally-bound and could therefore not be applied across cultures. The recognition that illness categories are cultural constructions remains an important facet of cultural competence in mental health. Kleinman (1978) also framed medicine as a cultural system, and explained the importance of understanding and negotiating between explanatory models held by patients and providers. The reflexive understanding of one’s own explanatory model and the ability to negotiate between explanatory models continues to be an essential skill for the provision of culturally competent care. The distinction between disease and illness also encouraged health care providers to go beyond the biomedical (treating the disease) and to consider social dimensions that contribute to individuals’ experience of health and illness (Kleinman, 1978). Kleinman’s ideas continue to be influential in psychiatry today, although the term “transcultural psychiatry” continues to be used to describe these concepts (Bhui, 1999; Kirmayer, 2007a).

 As the literature on the impact of culture on health began to emphasize the importance of a provider’s ability to negotiate culturally appropriate diagnoses and treatment plans, the focus of multicultural education began to shift from cultural sensitivity to a more skill-based paradigm, or cultural competence (Chin, 2000; Lavizzo-Mourey & Mackenzie, 1995). The new framework of cultural competence incorporated cultural sensitivity and the importance of respecting health-related beliefs and values, but it also aimed to incorporate provider skills in diagnosing and treating illnesses that may differ in prevalence, presentation, and in treatment response from what is described in diagnostic manuals (Kirmayer, 2012b; Lavizzo-Mourey & Mackenzie, 1995). In addition, cultural competence began to emphasize social justice and the importance of understanding patients’ broader socioeconomic context (Kumagai & Lypson, 2009; Liaison Committee on Medical Education, 2014).

 While multicultural education curricula often include the core components of cultural competence, many adopt alternative terminology in order to avoid the assumption that culture is something static that can be mastered. Instead, recent decades have seen the rise of programs that teach cultural humility, critical consciousness, and critical culturalism (Gustafson & Reitmanova, 2010; Kumagai & Lypson, 2009; Reitmanova, 2011; Tervalon & Murray-García, 1998). These programs often stress that health care providers must commit to a lifelong process of reflexivity and learning, and stress the importance of social justice in eliminating health disparities, something that critics of cultural competence say has been largely neglected in cultural competence training curricula (Gustafson & Reitmanova, 2010; Kumagai & Lypson, 2009; Reitmanova, 2011; Tervalon & Murray-García, 1998). The concept of cultural safety has also emerged due to dissatisfaction with cultural competence’s failure to address power dynamics as well as the narrow portrayal of culture as a fixed dimension (Browne et al., 2009). Many multicultural education curricula now incorporate aspects of cultural competence, cultural humility, cultural safety, and critical culturalism. While each framework has its own definition, each emphasizes the importance of providers’ awareness of and respect for cultural models and beliefs (Beach, Saha, & Cooper, 2006). Moreover, there has been a recent shift towards providing patient-centered care, a paradigm that emphasizes engaging all patients in negotiating treatment plans that meet their individual needs and sociocultural context (Beach et al., 2006; Kirmayer, 2012a; Saha, Beach, & Cooper, 2008). Cultural competence is sometimes perceived as being complementary or as a component of these approaches to health care (Owiti et al., 2013).

## 2.4. DOES CULTURAL COMPETENCE TRAINING IMPROVE OUTCOMES?

Although studies demonstrate that cultural barriers are a significant factor in creating disparities in health, there has been little research on the effectiveness of cultural competence training programs. Moreover, the studies that do exist evaluate a diverse range of training programs, ranging from half-day workshops to courses that are taught over the period of several years. The programs also vary in terms of their underlying frameworks, target outcomes, and in the number and professions of participants. Despite the diversity of the available literature, this section will aim to summarize the research on the effectiveness of cultural competence in improving provider-related and patient-related outcomes.

 The studies described in the following section were retrieved from searches of the PubMed, Medline (Ovid), Scholar’s Portal, and Google Scholar databases. The databases were searched using combinations of the following search terms and key words: cultural competence, cultural competency, cultural sensitivity, multicultural education, diversity education, cultural consultation, training, intervention, effectiveness, and efficacy. Additional articles were retrieved using references from other studies and systematic reviews, in particular the studies reviewed by Beach et al. (2005); Bhui et al. (2007); Horvat, Horey, Romios, and Kis-Rigo (2014). Studies that examined the impact of international exchange programs, focused on language concordance, or evaluated programs that aimed to improve cultural sensitivity with only one cultural group were excluded. Studies that focused on measuring overall provider satisfaction with the content of multicultural education workshops were also excluded, as these are largely recognized to be the weakest technique for evaluating training programs (Kirkpatrick, 1996). However, because of the limited number of studies of interventions that focus specifically on mental health or on cultural competence, studies that evaluated any programs related to multicultural education (cultural sensitivity, cultural diversity, cultural safety, etc.) and that focused on other areas of health were reviewed.

### 2.4.1. Provider outcomes

Studies that show statistically significant increases in provider-related outcomes are more common than those that indicate improvements in patient-related outcomes. However, this may be linked to the fact that many studies of provider outcomes evaluate training interventions in which the participants are pre-clinical medical counseling, or nursing students, while the participants in studies of patient outcomes are working health care providers and the interventions are often of shorter duration. Provider-related outcomes included provider awareness and knowledge of cultural issues, provider confidence in cross-cultural communication skills, and providers’ ability to recognize racial and cultural disparities in health. Studies measured these outcomes using self-assessment questionnaires, knowledge and awareness tests, and/or interviews and focus groups.

Of the seventeen studies that measured provider outcomes, all except one study showed a positive change in providers’ knowledge, skills, or attitudes related to cross-cultural encounters. Beagan (2003) examined the impact of a two-year longitudinal course for undergraduate medical students that aimed to produce culturally sensitive physicians. Interviews with two cohorts of third-year students (the first cohort was interviewed prior to the implementation of the new course and the second was interviewed after completing the course) found that students who had completed the course were no more aware of racial or cultural disparities in health or society than their counterparts who had not taken the course. Students in both cohorts were unable to recognize the impact of racial or sociocultural circumstances on their own experience or on the experience of physicians in general; they were also unable to identify diversity among their classmates. Students also felt that racism and discrimination were “generational” issues, or were only problems in uneducated, “redneck” areas; they overwhelming expressed the opinion that these issues are not relevant to clinical practice (Beagan, 2003).

Three studies showed improvements in only some outcomes, while the remainder of the studies found that cultural diversity training improved all measured provider-related outcomes. Shapiro, Lie, Gutierrez, and Zhuang (2006) used focus groups to assess first year medical students’ perceptions of an existing cultural competence curriculum at a public university. The study found that while the curriculum increased students’ (self-reported) awareness of cultural issues, students were not satisfied with their ability to balance between group-specific knowledge and respect for individuality (Shapiro et al., 2006). In a study of a 4-hour session in cultural sensitivity, Rubenstein, O'Connor, Nieman, and Gracely (1992) compared pre-test and post-test scores and found that medical students were more aware of the impact of patients’ health beliefs and practices on the clinical encounter, and were more aware of what resources are available for learning about such beliefs and practices. However, students’ knowledge of the pervasiveness of such health beliefs and practices did not improve. Farnill et al. (1997) evaluated the ability of a program to improve cross-cultural interviewing skills, and found that over seven months students gained confidence in their cross-cultural interviewing skills. An independent rater evaluated videotapes of cross-cultural interviews performed before and after the course, and concluded that while students’ inquiry skills and communication of positive attitudes did improve, their skills in communicating empathy and in using simple language did not (Farnill et al., 1997).

Twelve studies found positive changes in all provider-related outcomes. Carter et al. (2006), Crandall, George, Marion, and Davis (2003), Dogra (2001), Gany and de Bocanegra (1996), Hansen (2002), Hutnik and Gregory (2008), Majumdar, Browne, Roberts, and Carpio (2004), Owiti et al. (2013), and Tang, Fantone, Bozynski, and Adams (2002) each found that participants’ cultural knowledge and awareness increased after undergoing some kind of training related to diversity, cultural sensitivity or cultural competence. However, all of these studies measured cultural awareness using self-evaluation tools and Likert scale tests administered before and after training, which may be subject to social desirability bias. Joos, Hickam, Gordon, and Baker (1996) measured whether a 4.5-hour training session improved providers’ ability to elicit all of a patient’s concerns, and found that patients assigned to physicians who had undergone the intervention were significantly more likely to have all of their concerns elicited during the consultation.

### 2.4.2. Patient outcomes

The results of studies of the impact of multicultural training on patient outcomes are significantly more mixed. Seven studies that measured patient outcomes were reviewed; three found significant positive changes, three found no significant changes in patient outcomes, and one study found improvements in some, but not all, patient outcomes. Patient outcomes included mutual understanding, patient satisfaction, perceived quality of care, physical health outcomes, mental health outcomes, improvements in activities of daily living, adherence to follow-up or medication use, and patient opinions of providers’ expertness, trustworthiness, empathy, and unconditional regard. While several studies found improvements in patient satisfaction and patient perceptions of providers (Harmsen et al., 2005; Wade & Bernstein, 1991; Way, Stone, Schwager, Wagoner, & Bassman, 2002), studies that measured mental and physical health outcomes found no improvements in these areas (Majumdar et al., 2004; Sequist et al., 2010; Thom, Tirado, Woon, & McBride, 2006).

 Three of the most methodologically sound studies found no improvements in patient-reported outcomes. Majumdar et al. (2004); Sequist et al. (2010); Thom et al. (2006) each conducted randomized-controlled trials with 114, 124, and 53 health care providers, respectively, to determine the impact of cultural sensitivity and cultural competency training on a variety of outcomes. Patients in the study by Majumdar et al. (2004) completed a series of questionnaires to measure their satisfaction with the care they received, and to determine the impacts on their physical and mental health. A comparison in mean scores between patients in the control and experimental groups found no statistically significant differences in any outcomes, except in social and economic resources, with patients in the control group reporting poorer outcomes.

In a similar cluster randomized controlled trial conducted by Thom et al. (2006), participants completed a baseline survey that included a measure of physicians’ cultural competence as well as ten items from the Patient Satisfaction Questionnaire. The questionnaires were administered at 0 and 6 months to patients in both the control and intervention groups; a comparison in outcome variables found no change in either group, as well as no change in the secondary outcomes of patient trust, satisfaction, weight, systolic blood pressure, and glycosylated hemoglobin. Sequist et al. (2010) also measured the impact of cultural competence training on physical outcomes, and found that despite the training resulting in increased awareness of racial disparities in clinicians’ own practice, white and black patients continued to differ significantly in achieving desirable levels of hemoglobin, cholesterol, and blood pressure. Similarly, a study by Joos et al. (1996) found that while patients in the intervention group also had significantly better perceptions of the amount of information received, patient satisfaction, patient compliance with prescriptions and follow-up appointments, and outpatient utilization did not change.

 In contrast, Harmsen et al. (2005); Wade and Bernstein (1991); Way et al. (2002) found that multicultural trainings resulted in improvements in mutual understanding, patient satisfaction, and patient-reported recovery. Harmsen et al. (2005) randomly assigned thirty-eight Dutch physicians to receive an educational intervention on intercultural communication or to the control arm; patient interviews revealed 11% improvements in mutual understanding and 7% improvements in perceived quality of care among the intervention group, as well as positive effects on patient satisfaction and patients’ impression that physicians had been considerate.

Similarly, Wade and Bernstein (1991) randomly assigned patients to counselors who either had or had not received a brief training in cultural sensitivity. They then measured patients’ perception of counselors’ empathy, unconditional regard, and effectiveness. A comparison of scores revealed that clients in the intervention group were more satisfied with their counseling, rated their counselors more highly for expertness, trustworthiness, empathy, and unconditional regard, and were more likely to return for follow-up. However, the study’s sample was small, with only eight counselors and eighty clients.

Finally, a study by Way et al. (2002) examined client satisfaction before and after staff at an inpatient facility for mental health underwent a 3-day training on communication, interaction, respect, and cultural competence. The authors found improvements in patient-reported recovery, cultural competency, and in patients’ perception of their ability to express views and opinions without experiencing negative consequences.

 In addition, Kim-Godwin, Clarke, and Barton (2001) interviewed eight community health nurses, all of whom reported that culturally competent care resulted in positive health outcomes, including increases in prenatal care visits, higher immunization rates, increased help-seeking among migrant patients, reduced morbidity and mortality, increased compliance, improved trust, increased reported sense of self-worth, and increased interest in health promotion. However, data included in this study was collected through interviews rather than quantitative measurements, and the sample size was relatively small, with just eight community health nurses.

 Due to variation in the content and objectives of the interventions, it is difficult to draw conclusions about the effectiveness of cultural competence in improving outcomes. Several authors have pointed to a need for increased research in this area (Anderson et al., 2003; Bhui et al., 2007; Brach & Fraser, 2000; Cartwright, Daniels, & Zhang, 2008; Horvat et al., 2014; Kirmayer, 2012a; Kleinman & Benson, 2006).

Moreover, while much of the literature focuses on how cultural competency should *theoretically* improve outcomes and reduce health disparities, several studies reviewed above indicate that this cannot be taken for granted. For instance, Sequist et al. (2010) found that although their intervention improved providers’ awareness of racial disparities, those disparities did not change. Similarly, Majumdar et al. (2004) found that although providers understanding of multiculturalism improved and providers were more likely to adopt health care literature and consider social circumstances and culture to be important to clinical care, there was no impact on patient satisfaction, mental health, physical health, or activities of daily living. In contrast, Brach and Fraser (2000) suggest that cultural competence can be an effective tool for reducing disparities in health. The potential of cultural competence to improve outcomes and the mixed evidence from the few studies that exist suggest that more research is needed in this area.

 In addition, it is important to note that training programs led to more positive changes in provider outcomes than in patient outcomes. Studies have also focused primarily on evaluating the impact of interventions that *aim* to increase cultural competency or cultural sensitivity, rather than looking for links between culturally competent behaviours and positive outcomes. More research is needed in this are to determine if there is a link between culturally competent behaviors (as opposed to having undergone cultural competence training) and positive outcomes. It is also possible that the success of training programs in changing provider outcomes is due to the fact that the participants of these studies were largely students who had not yet begun practicing. It is possible that programs trainings are more effective when they target future-providers rather than health care providers who have already established patterns of behaviour in their interactions with patients. On the other hand, the success of these training programs may reflect volunteer bias, as students who are already interested in cultural issues may choose to take relevant elective courses. This is illustrated in a study by Godkin and Savageau (2001) in which medical students who elected to take a global multiculturalism course had higher levels of cultural competence than their peers in another track both before the course began and after it was completed. Students may also be more prone to social desirability bias in relating their experiences and changes in their cultural awareness; this may be the case especially where students are in an elective course, as they are likely to value cultural awareness and knowledge.

## 2.5. Discussion

Overall, the literature on cultural competence appears to fall into one of three categories. A large segment of the literature focuses on trying to define this concept and outline how it should be taught. A second set of publications aims to explore and describe the cultural competence training programs that have been implemented. A third set of studies aims to understand and measure the outcomes of these training programs. However, there appear to be significant discrepancies between what each of these categories is reporting. For instance, guidelines on cultural competence stress that training must be extensive, and should take place either in a dedicated course, or should be threaded throughout years of training. Frank and MacLeod (2005) argue that,

“All too often, diversity education is treated as incidental, taking the form of a ‘half day workshop on sexuality’ or a ‘cultural diversity day’, rather than being thoughtfully and thoroughly integrated into medical education curricula. This approach, which is intended to encourage acknowledgement and fitting treatment of difference may, in fact, contribute to the perpetuation of [stereotypes,]” (p.1178).

They postulate that “half-day workshops” approach diversity from a noncritical perspective, and therefore perpetuate stereotypes through an oversimplified celebration of multiculturalism. They suggest that teaching students to become reflexive and aware of power-relations in health systems and society as a whole can only be achieved when diversity is made integral to education. In contrast, descriptions and evaluations of training programs indicate that training may vary in duration from four hours to two years in length.

There are similar discrepancies between the guidelines and the results of studies that measure training outcomes. Following the arguments put forth by Frank and MacLeod (2005), one would expect the longest training to be the most comprehensive and therefore increase cultural awareness the most; however, the training with the least positive outcomes appears to be the training that lasted the longest (Beagan, 2003). Beagan (2003) evaluated perceptions of Canadian undergraduate medical students after completing a two-year course designed to improve sensitivity and competence related to culture; however, students who had completed the course were actually *less* able to identify sources of privilege than a cohort of students who had not completed the course, and concluded that culture was not relevant to their experiences or to physicians’ clinical work. Despite having met more of Frank and MacLeod (2005)’s recommendations for training programs than many other programs, this course was the least successful in achieving any positive outcomes while many “half-day workshop” training programs were in fact successful. While this may be a consequence of the outcomes measured and of the content of the training rather than the duration of the training, it does indicate that it cannot be assumed that longer is better in terms of the duration of training programs.

In addition to the variation in the training programs and guidelines in cultural competence, there are many older paradigms for dealing with cultural differences, as well as alternative paradigms that emerged from other theoretical frameworks. As indicated in the outline of the evolution of cultural competence, providers are now expected to respond to cultural differences in ways that are significantly different from what was expected even twenty years ago. Overall, the literature is characterized by diversity and contradictions that make it difficult to imagine what health care providers experience on the ground. This study aims to explore the experiences of a specific set of providers in a defined geographic area in order to better understand the experiences of at least a small population of health care providers. In addition, this study aims to shed some light on how the guidelines on cultural competence are being implemented in practice. Finally, it may provide insight into how health care providers access cultural competence training, and whether older providers understand and experience cultural competence differently than their younger peers.

# CHAPTER 3: METHODOLOGY

## 3.1. SAMPLING & RECRUITMENT

Participants for this study were recruited using a purposeful sampling strategy. The goal of purposeful sampling is to obtain richer data through differing opinions and experiences (Ploeg, 1999). In this case, maximum variation sampling strategies were used to recruit participants from different professions and from different work environments (Marshall, 1996). Recruitment aimed to include at least two participants from each discipline (i.e. nurses, family physicians, social workers, occupational therapists, psychologists, and psychiatrists), although this was not achieved in the case of mental health nurses despite the fact that a disproportionate number of attempts were made to recruit nursing professionals. Mental health care providers were contacted through email using contact information found on academic and professional websites; a standard letter of introduction was used to request their participation in an in-person, key informant interview. Additional participants were recruited using a snowball technique which consisted of using contact information provided by other participants (Marshall, 1996). In total, forty letters of introduction were sent, with fifteen providers agreeing to be interviewed for the study. Participants were recruited until the point of data saturation. Data saturation was understood to be the point at which no new themes emerged from the interviews, and when the sample adequately represented the different professions included in the study.

Of the fifteen participants, three were male and twelve were female. The fifteen providers who agreed to be interviewed represented a variety of professional disciplines and health care organizations. The study sample consisted of one clinical nurse specialist, two psychiatrists, two occupational therapists, two social workers, three family physicians, and five psychologists (including providers trained in neuropsychology, counselling psychology, and clinical psychology). Participants had experience working in hospitals, private clinics, community health centres, and schools. In addition, their educational experiences reflect the teachings of a variety of universities and different contexts. Participants attended schools in Canada (n=13), the United Kingdom (n=2), and Brazil (n=1). The learning experiences described in this study reflect participants’ experiences at Lakehead University (n=2), the University of Guelph (n=1), McMaster University (n=2), the University of Toronto (n=3), Windsor University (n=1), Memorial University (n=1), the University of Ottawa (n=1), the University of Alberta (n=1), and the University of Saskatchewan (n=1). Participants’ experiences also span a period of almost fifty years, as their graduation dates ranged from 1966 to 2011.

While recruitment focused on providers working in the Hamilton area, several participants were new to the area, and the majority of their professional experience was from surrounding areas. Some of the experiences providers described were therefore from other cities in Southern Ontario; including Brampton, Thornhill, and Toronto, and even farther north to Ottawa and as far as Thunder Bay.

## 3.2. DATA COLLECTION

The interviews for this study took place between October 2014 and February 2015. Thirteen interviews were conducted in person, and two were conducted by telephone. The interviews were semi-structured and lasted approximately forty minutes each. The interviews took place in locations chosen by the participants. Eleven took place in participants’ places of work, which included offices at clinics, hospitals, and academic institutions. Two interviews took place in private residences. Before each interview, participants were reminded of the purpose of the study, the potential risks, and the need to maintain patient confidentiality. Participants were also reminded that the information they provided would remain anonymous and they could refrain from answering any questions or withdraw from the study at any time. Interviews were recorded and transcribed verbatim with participants’ consent. Written consent was obtained at in-person interviews, and verbal consent was obtained and recorded before each telephone interview. Participants’ identities have been anonymized; the information they provided is referenced only by their assigned number.

The interview guide was written with the aim of gaining an understanding of providers’ experiences learning about cultural competence, and the strategies they use to provide mental health care to patients from diverse backgrounds. Each interview therefore consisted of three sections; the first focused on their learning experiences, the second on their professional experiences, and the third on their recommendations and concerns.

## 3.3. DATA ANALYSIS

A qualitative content analysis methodology was used to analyze the data. This methodology allowed an exploration of both manifest and latent content, as content analysis allows an analysis of both what individuals say, and the implications of what is said (Bloor & Wood, 2006; Graneheim & Lundman, 2004; Vaismoradi, Turunen, & Bondas, 2013). This methodology complemented an exploration of the impacts of the discourses used to understand and discuss the provision of health care for migrant and minority patients. In this vein, the conclusions drawn from this study are based on the assumption that discourse is constitutive, and that reality is constructed through language (Cheek, 2004; Talja, 1999). In addition, qualitative content analysis was an appropriate methodology as it allowed some quantification of the codes, although a descriptive approach was used to interpret the counts (Vaismoradi et al., 2013).

Analysis was conducted using individual interviews as the unit of analysis. This allowed each participant’s experiences to be considered for their uniqueness while also drawing common threads between cases (Ayres, Kavanaugh, & Knfal, 2003). This approach allowed some generalizations to be made while exercising caution in order to avoid homogenizing participants’ experiences.

As suggested by Mayring (2000), categories were developed using both deductive and inductive approaches. Deductive category application involved the use of a-priori codes, which were developed before the transcripts were analyzed and were informed by the literature. For example, the codes “skills,” “knowledge,” and “attitudes” were used to categorize participants’ learning experiences. These codes were used as the literature similarly divides educational approaches into these three categories. These categories were applied using explicit definitions and coding rules (Mayring, 2000).

Iterative codes were developed using a process described by Burnard (1991). Following this method, throughout the data collection process memos and hand-written notes were written in order to keep track of emergent themes. Memos written immediately following each interview recorded nascent ideas and helped to inform modifications to the interview guide, enabling a deeper exploration of these emergent themes. Burnard (1991) stresses the importance of becoming immersed in the data and the participant’s frame of reference. In order to facilitate this process, whenever possible notes were taken while visiting each participant’s place of work in order to retain a description of each waiting room or reception area. These notes included information about signs, advertisements, and reading material, as well as the languages of these resources.

Burnard (1991) suggests reading transcripts through several times in order to gain a preliminary sense of general themes. Following this approach, each transcript was read in its entirety prior to being analyzed. Using an open coding strategy, transcripts were read through and headings and categories were created to describe all content related to the research questions (Burnard, 1991). This process was conducted by hand using highlighters and pen and paper, as recommended by Burnard (1991). Next, transcripts were imported into N-Vivo 10 software, and categories were abstracted into hierarchies of codes (Graneheim & Lundman, 2004). The broader codes produced by this process facilitated the recognition of relationships between codes and commonality between certain participants’ experiences (Burnard, 1991; Graneheim & Lundman, 2004). The use of certain in-vivo codes, or codes that use the language of participants, allowed the analysis to stay close to the data while allowing a comparison of terminology used across disciplines (Sandelowski, 2000). Over multiple readings of transcripts, both deductive and iterative codes were applied and modified. This process aimed to support a reflexive practice and the incorporation of new insights, as recommended by Sandelowski (2000). A priori codes were helpful in understanding how participants’ experiences overlapped with certain frameworks for working in multicultural settings. Deductive and iterative coding processes therefore complemented each other and highlighted relationships between codes and cases.

Miles and Huberman (1994) recommend displaying data in order to facilitate comparisons between the units of analysis. Tables were created to allow comparisons of experiences and perceptions across participants’ educational background (including specific courses and year of graduation) and professional disciplines. Tables were also useful in displaying both relationships as well as quantitative information about the data. For instance, they were used to highlight how many times certain issues were raised by certain participants.

## 3. 4. ANALYTICAL FRAMEWORK

Throughout this study, the codes and findings were analyzed through a lens informed by critical discourse theory. Discursive practices were examined with specific attention paid to their implications for structures of power. For this analysis, discourse was understood using Lupton’s (1992) definition, as cited in Cheek (2004), of discourse as “a group of ideas or patterned way of thinking which can both be identified in textual and verbal communications and located in wider social structures,” (p.1142). Discourse was understood to be sets of patterned thinking and common assumptions that make up discursive frameworks, which, as explained by Cheek (2004), “order reality in a certain way [and] both enable and constrain the production of knowledge, in that they allow for certain ways of thinking about reality while excluding others.” As participants’ statements were understood as fitting into discursive frameworks such as “cultural competence,” “cultural sensitivity,” and “evidence-based medicine,” the discussion section of this paper explores how these discursive frames shape the taken-for-granted understandings that influence the provision of health care. This lens was similarly used to guide an exploration of how discursive frameworks can both privilege and marginalize certain ways of understanding and experiencing health and health care practices, and how these processes affect the ways that providers understand cultural competence. Attention was paid to how these discursive frameworks and practices can privilege certain social actors through Othering and marginalization (Dutta, 2007).

# CHAPTER 4: FINDINGS

This chapter describes key themes that emerged in discussions about participants’ experiences with cultural competence. Interviews with mental health care providers (n=15) revealed that while participants were comfortable discussing cultural competency and their ability to provide culturally competent care, providers in fact hold very different beliefs about what constitutes cultural competence. While every interview included a discussion of “cultural competence,” the definitions that participants provided for the term varied significantly. Moreover, some participants had never heard the term “cultural competence,” although they felt they could imply its meaning. In addition, providers had diverse reactions to the term “cultural competence,” and whether or not they felt equipped to provide culturally competent care. Many participants used other terminology, with different implications for practice, to discuss issues related to cultural competence.

## 4.1. ACADEMIC LEARNING

Participants’ experience with cultural competence seemed to be largely a consequence of their educational experience. Participants’ educational experiences varied in terms of whether that learning took place in a classroom or in practicum placements, whether courses were dedicated to cultural issues, and whether courses were elective or compulsory. There also proved to be significant variation in participants’ experiences with continuing education. Some participants had attended and had also organized continuing education sessions about cultural issues, while other participants had never heard of such sessions. This section will explain how participants’ experiences learning about cultural issues appear to impact their understanding of cultural competence.

### 4.1.1. Elective versus compulsory training

Compulsory credits related to cultural issues proved rare. For the majority of participants, cultural issues were either embedded in other course material as secondary learning objectives, or were included through professors or practicum supervisors who were particularly cognisant of cultural issues. In this sense, it seemed that whether or not providers learned about cultural issues was largely a matter of chance. One psychologist explained that while he could only recall being told “to be culturally sensitive,” he felt that he had learned more about cultural issues through his practicum placements and practical experience. He explained,

“During my practicum placements, so that’s when I was still a student, it would have come up in that sector as it came up in the hospital. So if I had a patient who was from another culture, my supervisors were really good about making me aware of cultural variations and that, but that had no relation to the university itself. It was just, yeah, that I had a really good supervisor,” (P3).

Most of the participants who have attended continuing education sessions related to cultural learning had also taken courses related to cultural issues while in school. These participants also often suggested that elective courses they took about cultural issues should have been compulsory. One participant, a psychologist who audited an elective course on ethnic cultures said,

“So it was useful to take it, I just wish it was more of a required course. You know, I mean I still got the information but I wish it had been, like while I was going through the program, that it had been a required one as opposed to just take any one you want kind of thing,” (P8).

In contrast, participants who either did not take any courses about cultural issues often expressed the opinion that there is simply not enough space in the curriculum to include specific courses for cultural issues. For instance, an occupational therapist explained with reference to the absence of a course about cultural issues in the curriculum,

“Because there are so many other things we need to learn about, not to say this is not important, but there may be more technical skills, orientation, things that we need to learn about, and keeping atop of best practice and evidence-based practice. So I don’t think… I mean maybe this tends to be short-shifted, that people don’t think about it as an important aspect,” (P11).

 Providers also explained that they are able to choose what continuing education sessions they attend. Numerous participants mentioned the involvement of their regulatory bodies in ensuring that their members are engaged in lifelong learning, but that the actual topics chosen to attend are entirely up to the learner. One occupational therapist explained,

“It’s up to you to decide what you feel you need as a… to be competent. And I think that’s very in-line with being self-directed, being an adult educator, adult learning principles, I think that um, you know if you feel that that’s an area that you need more help in, then that’s… the way that our college is set up, is that every year we need to develop our portfolio, which identifies, okay how, what are your gaps in professional competencies […] What are your gaps, and what are your objectives, and learning plan to address those gaps, so if you don’t identify this as a gap, then you wouldn’t necessarily, you know, go into that.” (P11).

Several of these participants then mentioned that individuals who are not already interested in cultural issues are unlikely to pursue these training opportunities. One participant who had attended continuing education sessions about cultural issues was asked if he believed his peers were as likely to be interested in learning about culture:

“I would say – my answer would probably be no. I don’t think so. And I’ve seen – I think I’ve seen – in peers, and not necessarily people I immediately work with, I just mean kind of a – an occasional ignorance of kind of cultural stuff. […] So I think that you know, there’s a lot of misunderstandings and stigmas and things like that, which from my experience aren’t very accurate. And I think that comes from having sort of a narrow exposure with those types of thing.” (P3).

Another participant described the flaw in her professional association’s approach to self-directed learning, saying,

“And you just fill it out, and if there’s barriers or if you need more education, then you set goals. So you don’t have to have goals for each section, but you can. So if someone is feeling that they need – but that’s your self-awareness, right? So if you’re not self-aware, you wouldn’t put that as a goal!” (P4).

This study cannot determine if training about culture causes students to become interested in cultural issues or if students enrol in courses because they are already interested in the subject. However, it is clear that with a self-directed approach to continuing education, people either appear to learn lots about this issue, or learn nothing at all.

Several participants, largely those who did not take courses about cultural issues in their professional training, suggested that there would be little benefit in attending continuing education sessions dedicated to cultural competence. Participants often mentioned that they preferred to attend sessions that were “practically” as opposed to “theoretically” useful. In addition, several providers who have attended such sessions indicated that they are not usually popular, and felt this was a consequence of a general sentiment that training in cultural issues is not useful. One psychologist explained that the lack of available trainings on cultural issues is a consequence of a widespread perception that cultural competence training is not immediately beneficial, stating, “Because people want to pay $150 for something that they’re going to feel that absolutely they can use the next day,” (P3). Several barriers to attending continuing education sessions were raised during interviews. In addition to the cost of sessions, participants mentioned the limited amount of time and resources they can dedicate to continuing education. One psychiatrist explained that he had to dedicate his time to more “relevant” learning opportunities, and said, “So if you tell me about a workshop in cultural aspects, I think the topic is important and fascinating but I really don’t have time to do it. That’s why I say, you know, it doesn’t even spark an interest because it’s not possible for me,” (P2).

 Additionally, many participants who had not taken courses related to cultural issues felt that these skills and knowledge could be gained more through experience than through academic training. A family physician explained,

“I’m not sure that medical school is really the right place for it, because it’s something that I think is so obvious. That… I’m not even sure how… I guess because I haven’t been to any lectures I’m not sure how it would even be helpful. I think it’s something that comes in the later years of medical school once you start seeing patients, although people start seeing patients earlier now in med school… residents see certainly, that’s where you start learning about how to deal with patients and you are dealing with them,” (P14).

Participants who were unfamiliar with the concept of cultural competence and who had not received any education on the subject often defined cultural competence as an attitude of openness and respect, and therefore felt that these attitudes are innate rather than something that can be taught.

In contrast, participants who had learned about cultural issues in an academic setting did not question the value of courses dedicated to cultural issues, and gave numerous examples of situations in which knowledge and skills that they learned in these courses were useful. Many participants recognized that they are more interested in cultural issues than their coworkers and peers. A common issue raised by participants was that although their colleagues may not be as interested in cultural issues, they often agree that cultural issues are important. For instance, while discussing her knowledge of emerging trends in education around cultural issues, one physician was asked whether she felt her colleagues were equally familiar with the literature. She responded,

“No. No. I think you have to have a very active interest, an engaged interest in it; they don’t reject it- you know if you’re going to give it to them, they don’t have to go off into a whole new area of literature to find this out then they’re going to accept it. They’ll say “oh yeah, that’s interesting”. Oh yeah, I have a great group of people to work with here. Yeah but they don’t necessarily want to go following the ideas like I do,” (P13).

Several participants similarly recounted stories in which their coworkers acknowledged cultural issues when it was brought up, but would not have recognized the problem on their own. In one example, a psychologist recounted an event in which a colleague expressed concern that certain magazines in their waiting room might be offensive to some of their clients. The participant explained that once it was suggested that the magazines might be offensive in some cultures, other colleagues agreed even though they had not thought of the issue themselves. He explained,

“So it’s something that got brought up as a discussion, certainly, you know in hindsight people were immediately like, ‘you know that makes sense, we really shouldn’t put them out there.’ But that didn’t happen until someone sort of brought up a complaint about it,” (P3).

### 4.1.2. Content of Training

The findings of this study suggest that the content of cultural training can vary significantly. Some participants felt they developed practical skills, while others felt their training helped to shape their attitudes in a more abstract way. The variety of ways in which cultural issues are taught is reflected in the diversity in providers’ understandings of cultural competence. This section highlights key themes that emerged in discussions about the content of training.

#### Attitudes and Reflexivity

Several participants described how their education focused on teaching certain attitudes with regards to culture. These attitudes often include reflexivity and an awareness of participants’ own assumptions, biases, and prejudices. One social worker summarized her educational experience, saying,

“I don’t think that there was anything specific, like any, ‘this is a tool or a strategy or a framework to work from.’ Um, I think that by virtue of touching on these things throughout my education, experiencing them throughout my personal life, it really helped to have an impact on how I perceive things. So it helped me to maybe be more culturally sensitive than I would have had I not had the course where we would talk about, um, different cultural perspectives. So I don’t think that there was any… again my memory, but I don’t think that there was anything that was black and white, ‘Oh, I need to do this because I learned this,’ it was more, it helped to shape and mould,” (P9).

Among the attitudes taught in courses, several participants identified the importance of learning to be reflexive and to understand their own cultural background. Multiple participants brought up the fact that they had not considered themselves as having a cultural identity until they took a class in which reflexivity was a topic (P1; P6; P8). One psychologist discussed how a course on cultural issues helped her to understand culture in a broader sense:

“I think the class that I audited made that really aware, because to be honest, before that I hadn’t really thought about it, and again, I hadn’t had at that time too many clients that were from different backgrounds, and I was starting to see at that point in time, and that was one of the things that, when a professor sort of brought that up, it was like ‘woa,’ because being born and raised in Canada, I hadn’t really thought about having a culture myself, you know… I’m not Italian, or I’m not Polish, or I’m not, you know… Japanese. I don’t have those sorts of backgrounds, so I hadn’t really thought about just being, born and raised in Southwestern Ontario, that that itself could be a culture, that I’m female; that’s a culture… the fact that I’m highly educated; that’s a culture. I hadn’t thought about culture in terms of those broader senses of the meaning of the word. So that class, even though I wasn’t… like I was just auditing it, it was really an eye-opener in terms of what culture means, and how it could be influencing things. So it made it much more clear, the kinds of things to be aware of,” (P8).

Providers whose education focused on instilling attitudes and awareness often mentioned that focusing on knowledge about cultural groups increased the risk of promoting stereotypes. Several participants brought up the idea of treating patients or clients first and foremost as individuals, and not assuming that because of their cultural background they will behave a certain way (P4; P9). This idea surfaced several times in the context of providers’ recommendations for cultural education. One physician explained that the focus on attitudes rather than knowledge is necessary, saying,

“And that has to, that has to be… I think it’s a never-ending cycle of training and awareness building. It’s more awareness building than training. Because as soon as you have a training program it takes away the affective elements of it… you know, so now what am I supposed to do in my cultural interview… on the checklist… […] we have to keep on inculcating these values and practice expectations into people at a feeling level, not at a skill-acquired level,” (P13).

#### Transcultural Knowledge

 In contrast, other participants described learning experiences that seem to focus more heavily on building providers’ knowledge about the factors that influence cross-cultural interactions. Several providers discussed the value of knowledge they gained from courses. These providers described courses that taught them about different expressive cultures, how body language varies between cultures, and the role of cultural background in determining the challenges and barriers that their patients face (P1; P6; P10). One psychologist described an educational experience that was largely oriented around acquiring this type of knowledge:

“Tons of things about English as a second language, that’s a really big deal. One of the things that I do is psycho-educational assessment, so that’s a critical piece in terms – well both culturally and language – related to… so if you’re measuring someone’s IQ, or… there’s all kinds of things that could be different; it can be inaccurate for all kinds of reasons. […] So for example that eye-to-eye gaze may not be rude, or aggressive, or appropriate. And rude or strange if you’re not, right? And whether you would shake someone’s hand. A sense of time? You know, whether someone’s being on time for an appointment, or early or late, whether that’s rude or… or just sort of expected and normal. Um, things like that. How you would talk about things. So there’s just sort of general cultural personalities, but then there’s that but there’s also the individual,” (P6).

#### Categorical Knowledge

Overall, the majority of providers described learning about norms and behaviours that vary across cultures rather than characteristics specific to any one culture. However, some providers had taken courses dedicated specifically to learning about First Nations issues, which included access to culturally appropriate health care (P4; P9). In addition, participants’ descriptions of continuing education sessions indicate that these trainings focus largely on specific groups of patients, such as refugees from war-torn countries (P3) or specific ethnic groups (P8).

#### Knowledge of Community Resources

Often, continuing education sessions were provided by community organizations, such as settlement services, and therefore focused on the resources and services that those organizations provide (P4; P5; P12). For instance, one participant described a continuing education session in which community resources were discussed:

“And it’s the networking. It’s nice to go out there and meet with somebody else and say like, what are you doing in your workplace, or what’s the Hamilton community doing. And from that I then have resources. So if I see someone, I can say, ‘Oh, I know this person that’s doing that,’ or, ‘Oh, I know this program.’ Especially when it comes to ethnicity, cultural ethnicity programs […] Anyway it had tons of great supports there for newcomers in Hamilton but those services have now split up into other agencies, so it’s kind of it’s always interesting to know what agencies will support a newcomer,” (P5).

#### Intercultural Communication Skills

 While fewer participants felt their professional training helped them to develop skills for working with culturally diverse clients or patients, those who did described learning about inter-cultural communication and the effective use of interpreters. One psychologist recalled a lecture in which a professional interpreter gave specific instructions on how to work with interpreters. The same participant later explained that the content of the course focused largely on *how* to modify one’s practice, and her understanding of cultural competence was similarly oriented around providers’ ability to modify their practices in order to meet the needs of their patient. In one case, she explained,

“So for the interview we used an interpreter for that person’s native language to make sure we got that information correct, to remove that, and then we also had use of an interpreter as needed during the assessment, and […] we modified the battery significantly,” (P8).

## 4.2. PROFESSIONAL DISCIPLINE

The second factor that appears to influence how participants understand cultural competence is their professional discipline. Providers within the same discipline appeared to use similar language when discussing cultural issues, and also described using similar strategies to provide what they felt to be culturally competent care.

Participants’ responses in interviews showed that the terminology and language used to discuss multicultural health care varies between professional disciplines. The term “cultural competence” was frequently used because of the research question and interview guide; however, participants also employed a number of other terms, which, while similar, have different meanings and theoretical underpinnings. These terms included cultural sensitivity, cultural awareness, transcultural psychiatry, person-centeredness, and diversity. These words were often employed as synonyms for cultural competence or in descriptions of care that is culturally appropriate. Interestingly, providers often defined cultural competence using the related terminology most commonly used in their professional discipline. It appeared that most providers felt they were talking about cultural competence, when in reality they were discussing a concept that is similar but that has different implications for care.

### 4.2.1. Cultural Sensitivity

More than any other professional discipline represented in this study’s sample, psychologists and participants trained in counselling psychology used the term “cultural sensitivity.” The term was often used to describe how providers should react in situations in which their values and those of their patient differ. For example, one psychologist described a situation in which a second-generation immigrant youth struggled to reconcile her parents’ values with the realities of being an adolescent in Canada. The participant explained,

“Um, where I try to come very much on that one is that, being sensitive and not – it’s really important to be respectful as well, but being sensitive to “yes, but this is how we’ve always done it. This is how my parents did it and this is how we’ve always done it,” and appreciating and trying to help parents understand that yes, this may be the way that things were done and I maybe can’t understand because I’m not from that culture, but your kids are living here. And here’s the challenges they have, of trying to sort of be like teens and find their way and do what they’re doing, but also find a way to be a part of their family. And trying to find some ways, and sometimes it’s collaborative; how do we find a way that works for your family to do this. And being respectful and encouraging, saying, ‘okay, here’s what we know here’s what we understand, that works very well… so how do we find a way that makes it work for you?’” (P10).

It was often implied by participants that cultural sensitivity was an attitude (as opposed to a skill or a type of knowledge). Participants often used the term “cultural sensitivity” interchangeably with the word “respectful,” suggesting that participants perceive cultural sensitivity as a personality trait or an attitude. Participants, especially psychologists, also spoke of the importance of “being sensitive” when providing care. Cultural sensitivity was perceived as something that psychologists and mental health care providers must *be* as opposed to something they must *do.*

### 4.2.2. Cultural Awareness

Variations of the term “cultural awareness” were used with greater frequency than any other term to talk about how health care providers should provide care to culturally diverse clients and patients. Every participant in this study, regardless of discipline and educational experience, raised the importance of being aware of diversity and of cultural variation.

 Interestingly, however, the term “awareness” was used differently across professional disciplines. For the majority of participants in psychology and psychiatry, the term “awareness” was used in reference to having specific knowledge or of being aware of specific norms that vary across cultures. In contrast, however, family physicians, occupational therapists and social workers spoke more generally about being aware of the existence of different cultural and individual differences. One social worker explained,

“Well you have to be aware of the different perspectives and realities of different people. […] Just, it’s needing to be aware that just because we as an organization may value one way of intervention, it might not be that way for everyone,” (P9).

Participants from these disciplines also often defined “cultural competence” as being culturally aware. For example, when asked what cultural competence meant to her, one such social worker responded,

“I think it would mean being aware, and being aware that you know – being aware of different cultures, various cultures, lots of cultures… being aware that you don’t necessarily need to know everything about the culture but being aware that everyone comes from somewhere. You know from a different perspective – comes from a different perspective, culturally. I think being understanding and non-judgmental of you know, any culture. But I think it’s the same with people in general. Like if you just have a non-judgmental viewpoint of everybody and you’re doing – everybody comes from a different family,” (P4).

The social workers that participated in this study appeared to link awareness more closely with an awareness that there are no universal values or norms. In fact, another social worker even explicitly mentioned the importance of being aware that one *cannot* know everything. She explained,

“Being aware that you don’t necessarily need to know everything about the culture but being aware that everyone comes from somewhere. You know from a different perspective – comes from a different perspective, culturally,” (P4).

 For other disciplines, however, awareness seemed to indicate possessing a knowledge base related to cultural norms and values. Awareness was associated largely with specific knowledge about cultures and cultural groups, as well as about factors that may vary between cultures. Psychologists, mental health nurses, and psychiatrists each spoke at length about the importance of being aware of differences in language, non-verbal communication, in interpretations of symptoms, and barriers to accessing care.

### 4.2.3. Person-centeredness

 Social workers, family physicians, and occupational therapists often emphasized the importance of person-centeredness and felt cultural competence could be achieved through the provision of person-centered care. These providers indicated that being aware of the existence of different ways of perceiving the world is crucial for the provision of client- or person-centered care. Occupational therapists and social workers each stressed the importance of client-centeredness and person-centeredness, respectively. Family physicians discussed both human- and patient- centered care (P12; P14; P15). Participants from each of these disciplines often emphasized that cultural competence was indistinguishable from these concepts, as they strive to take every client or patient as an individual.

 One occupational therapist explained the link between client-centeredness and culture, and how culturally competent care can be delivered through a commitment to client-centeredness:

“Like if I think that I have my own way of looking at the world and based on my own experiences in the past, and like… but I think more importantly is that health care providers can be reflective of those and be able to identify and address them in a way that works, and still maintain client-centered practice. I think the other thing is that it’s impossible to know everything about your clients, so that’s where your openness and willingness to learn, and ask questions! You know, find out from your clients, what is important to them, and what their goals are relative to their culture,” (P11).

Participants from disciplines that emphasize client or person-centeredness indicated there was little difference between interacting with someone from a different cultural background and interacting with someone from the same background. Social workers and occupational therapists often explained that the strategies they use and the questions they ask vary between *all* patients, not only those from different cultural backgrounds. For example, one social worker explained how clients’ perspectives may vary based on “so much more” than their ethnic culture. Consequently, she felt that her interactions with people from different cultures were similar to her interactions with any other client:

“But I think it’s the same with people in general. Like if you just have a non-judgmental viewpoint of everybody and you’re doing – everybody comes from a different family. Different families, it doesn’t matter what country or language, or religion or anything, they come from a different family and a different perspective,” (P4).

She also explained that she may or may not even explicitly address a client’s culture, depending on the interaction:

“And this goes back to the person-centred approach, I think that if somebody talks about their culture and that their culture is a barrier to coming to counselling for example, or their culture is – you know there’s something about their culture that isn’t as… if it’s a barrier for them, or they want to talk about it, then we’ll go with that. Right? And that goes back to like I said being more person-centred. I think you can’t really assume that because someone is from any culture, that they – that any – you can’t assume anything different than anybody, right?” (P4).

Similarly, a family physician explained that cultural considerations are largely subsumed within the “human-centered” approach to health care:

“I connect on the human level. And then if that comes up, which it often can, then we would talk about it then. Unless that’s the issue, right? If they come, and that’s the issue, then we may have to connect there and then talk more about what’s that like for you, or…” (P15).

Additionally, an occupational explained that when looking at culture through client-centered lens, ethnic culture is considered in the same way as other “cultural factors” that may influence a client’s perspective or goals. She explained,

“I had to think about the whole issue of client-centred practice and in context to culture… and when we talk about culture, we think about it not necessarily in terms of just ethnicity and race, and so forth; we also think about it in terms of their social culture, and their environmental culture that they live in, so…” (P11).

### 4.2.4. Diversity

 The social workers that participated in the study used the term “diversity” much more frequently than any other participants, and had taken courses that were specifically related to the concept of diversity. The concept of diversity was often used in reference to the provider’s attitudes, in phrases such as “practicing from a culturally diverse awareness,” “respecting diversity,” and “working with diversity.” In contrast, when providers from other disciplines used the term “diversity,” it was largely in reference to the diversity of their patients or the ethnic make-up of the staff at their workplace (P6; P12).

### 4.2.5. Transcultural Medicine or Psychiatry

The term “transcultural” was only used by psychiatrists and psychiatric nurses. Unlike the other vocabulary discussed in this section, the word transcultural was used as an adjective to describe “health care” or “psychiatry,” rather than to describe the provider or the way the provider works. These words were most often used to explain how to provide care despite the fact that psychiatry and many diagnostic tools are a product of Western culture, and may therefore conflict with the values of patients from other cultural backgrounds. For instance, in describing a global-health nursing course, a mental health nurse said,

“We talked about just like transcultural health care and psychiatric health care especially in psychiatric- um psychiatry, you have to be very aware that the DSM is a very westernized view of medicine. So we looked at how the DSM could be interpreted differently in different cultures and how diagnoses could be seen differently,” (P5).

Another participant, a psychiatrist, described how in order to practice transcultural psychiatry, it was a “rule” that phenomena that have cultural meaning should not be medicalized: “Well, there has been… you know the exclusion from, from judging somebody’s beliefs as psychotic if those beliefs are firmly based in cultural practice or in religious belief or whatever. And that has always been there; I’m not sure that everybody is aware that that’s a rule…” (P7).

### 4.2.6. Assessing Cultural Competence

 Professional discipline also appears to play an important role in how mental health care providers perceive culture and their ability to assess their own cultural competence. For instance, in comparison to other health care providers, psychologists appeared to be more comfortable assessing their ability to provide culturally competent care. The psychologists who participated in this study often linked “cultural competence” with the competencies required in licensing with the College of Psychologists. Overall, they also appeared more comfortable with the term “cultural competence,” where participants from other professional disciplines expressed qualms about the term itself. The familiarity of the term “competence” and with assessing those competences may be responsible for psychologists perceiving the term “cultural competence” in this way. For instance, when asked to define cultural competence, one psychologist explained,

“Well I guess it’s one of the areas in having to sort of declare when you’re registering… and it was a muddled definition. I think probably it just means being aware, sensitive, and respectful of cultural difference. And I think really on the large scale, I don’t think… like being sensitive, aware, and perceptive… respectful. Appreciating that we all come from different perspectives, different backgrounds that affect how we view the world, and how we exist in the world. Yeah… And so then being able to, as a therapist, appreciate that and then not make assumptions about clients based on what we think we know about them,” (P6).

Several psychologists mentioned licensing competencies and having been tested on cultural competence prior to registering with the College of Psychologists. Often, the definitions of cultural competence provided by psychologists were related to the content on which they had been tested. One psychologist explained how the College of Psychologists ensures that its members are competent upon registering:

“And they need to, by the end, by the time we finish our process of registration with the College we need to declare competency in certain areas. Depending on what we’re wanting to do. So it’s just sort of reflecting on things, so are you competent to… do you, like can you demonstrate sufficient knowledge of assessment and diagnosis that you could do that effectively in your practice; are you competent? So that kind of stuff, and then there was a lot around cultural and individual differences that we had to show that we had sufficient knowledge and background to show that we’re competent in those areas, that kind of stuff,” (P10).

 In contrast, participants from other disciplines often expressed the belief that cultural competence was not something that could be measured or achieved. One occupational therapist criticized cultural competence for this very idea, explaining, “[…] competence indicates that it’s a skill that can be learned and then put on the shelf until I need it again,” (P13). Similarly, a family physician expressed her dislike for the term “cultural competence” and criticized the arrogance required to state that one’s actions are “culturally competent.” She explained,

“I don’t really like the term cultural competence. Because unless, unless that’s where you’ve been for a very very very very very long time, I don’t think you can… yeah I think it would be arrogant to think that you’re competent in any culture but your own. Sometimes I don’t even think I’m competent in my own culture, so…” (P12).

The same provider explained that while she would not be comfortable calling herself “culturally competent,” she would describe herself as “culturally aware” or “culturally sensitive.”

Interestingly, other providers assessed their own level of cultural competence very differently. Providers from disciplines such as social work and occupational therapy, in which client- or person-centeredness are key tenets of their work, often felt that they provided care that was culturally competent in every interaction, because culture is always a consideration. One social worker, when asked if she could describe a situation in which she felt she provided culturally competent care, explained,

“Um… I think, doesn’t that kind of happen all the time? Even when I’m working with people from my own culture, you’re being culturally competent like, not, um, that they’re a different culture, but their cultural reality of maybe even their family may be different. So I think that I attempt to be culturally competent in all my interactions with everybody, and not to make assumptions that my way is the way that they experience life, even if they come from what I perceive to be as my same culture. And that would be like, even like my… if I was… I mean it obviously wouldn’t be, but like…if I had somebody who had the similar kind of upbringing and parents and family and kind of, make-up, I can’t assume that my reality is theirs or that my experience has been theirs. So I think it goes beyond the different visible cultural differences,” (P9).

## 4.3. PERSONAL EXPERIENCES

Personal factors and experiences also appear to play a role in determining how participants understood cultural competence. Participants primarily spoke of exposure to diversity, generational differences, and personality as factors that influence cultural competence.

### 4.3.1. Exposure to Diversity

Several participants mentioned the importance of exposure to diversity in determining their ability to provide culturally competent care. For instance, one psychologist explained that while his parents exposed him to diverse cultures as a child, had he not had that experience he would have felt unprepared to work as a psychologist in a multicultural setting. He explained,

“So I had that sort of built into my childhood. Um, but I think of a lot of my kind of colleagues and friends and they didn’t have that kind of experience that I had and they often felt, I think, kind of ill-equipped to where they ended up. Um, because you know they go where the jobs are, and sometimes the jobs will be in a fairly narrow region […] Um but I think that overall, I would say that most people including me would be ill-prepared coming out. I just was an exception to the rule because of the opportunities that I had.” (P3).

Moreover, he went on to explain that he felt that his exposure to cultural issues at a young age was responsible for his continuing interest in learning about culture and cultural competence (P3).

 Another participant explained how her childhood experiences played a role in shaping her personality and her ability to be open to other cultural beliefs and practices:

“I think about my own family […] growing up, we always had, often at Christmas, we would have […] international students join us because they had nowhere else to be. So I remember growing up with these poor African people sitting in the living room in my dad’s parka and mittens and a tuque just shivering while we were roasting because we’d turned the heat up as high as we possibly could! So I was exposed to just being welcoming um, welcoming and hospitable to people from other cultures from a young age,” (P12).

 Several participants, including some who had taken courses about cultural issues, nevertheless felt that the majority of their cultural learning came from experiences in which they were immersed in a different cultural group.

 Many of the participants, who are also professors in their respective fields, stressed the value of exposure to diversity and the role of international placement opportunities offered in each of their programs. In addition to objectives related to capacity building in developing countries, the primary objective of these programs appeared to be exposing students to diversity and cultural variation. One psychiatrist explained, “And we wanted to… to start something which would have people thinking about different cultures and how you relate there, and so on,” (P7).

### 4.3.2. Generational Differences

 Several participants discussed the role of providers’ age in determining their perception of cultural competence. Participants raised the issue that there have been major changes in the way cultural issues are both taught and dealt with in the clinical environment, as well as the role of age in determining how open providers are to those changes.

 Participants’ educational experiences clearly showed a change in how cultural issues are taught and included in curricula. For instance, the only psychologist to have taken a compulsory course on cultural competence was also the most recent graduate. None of the participants who graduated before 2000 had taken a course dedicated specifically to cultural issues, and most of these participants felt they had no exposure to cultural issues in their education at all. It appears that specific courses about culture are offered more now than ever, and are increasingly included as compulsory rather than elective credits. Cultural issues are also more mainstreamed, and especially with the increase in problem- and scenario-based learning methods, they are more likely to be discussed in the context of other courses. One psychologist explained that older providers who haven’t had the same cultural education might still be culturally aware; however, there is still a difference in their ability to provide culturally competent care. She explained,

“I think that the more and more training, and I know that cultural competence is sort of one of the big up-and-coming things in programs, so I think the more of us that are getting trained in that, the better it is, but I don’t think necessarily everyone has that background. […] I think it’s just, not that they’re unaware especially if they working in a setting where there is a lot of diversity. But I don’t think it’s the same necessarily in terms of the understanding, and again, that attitude and perspective and keeping that in the back of your mind,” (P1).

 An additional generational factor that plays a role in cultural competence is providers’ openness and acceptance of new ideas about dealing with cultural differences. Providers mentioned the fact that as people age they become more entrenched in their own belief systems. One occupational therapist explained that while age and experience may benefit their practices, there might also be certain drawbacks:

“I think it depends on the complexity of the case, and it also depends on the therapist’s level of experience. So a new grad, versus somebody who’s been working for ten, twenty years… I think, but again just because you’ve been working for a long time, you may be entrenched in your own practice approaches, which may not be very good either,” (P11).

### 4.3.3. Personality

 The final factor that participants felt affected their ability to provide culturally competent care was personality. Participants often mentioned that they had always been “open,” “non-judgmental,” or “idealistic,” and that they felt these personality traits made them better able to provide culturally competent care. For example, one physician explained how personality is a key determinant in why some providers are better than others at providing care to migrant patients:

“Oh, personality. Some people are just naturally more open, and um… less welded to their beliefs and opinions and so on. Some people are just naturally much more, yeah. And you know I think in me it’s something that I’ve recognized that I need to work at. Um, uh… Yeah, kind of a guilty confession, but you know I still recognize that sometimes if I see someone on the street who I don’t know, who looks different than I do, who appears to be from a different culture than mine, I can jump to all sorts of conclusions about that person And I hate it that my brain does that! And I catch myself immediately but my brain still does that. And I think there are other providers here whose brains don’t do that. Like they don’t, they don’t have as automatic a response […] And I know that that’s, you know, that’s still in my head! And I think other people don’t have it in their heads. So I have to battle with it being in my head, and I by and large successfully do, but I still have, I still have some very inappropriate instantaneous reactions at times, and that I shouldn’t. So yeah,” (P12).

 Interestingly, some participants also indicated they felt that they were inherently able to provide culturally competent care because of their personality. A social worker explained that she felt she did not need to do anything differently in her interactions with clients from a different cultural background because of her personality. She said, “I mean, I’m validating to everybody and I’m accepting of everybody so I didn’t have to do anything differently. Not that I can think of,” (P4).

This sentiment was also cited as a reason why students feel that courses on cultural competence are unnecessary. One participant described students’ reactions to a course on cultural competence, saying,

“But I think there were other people that kind of thought it wasn’t important enough to have a full course on, just in terms of that it should be something that we just do and take for granted, and not something that needs to have a full course in,” (P1).

This perspective was also common among participants who had not taken courses in cultural issues.

Lastly, one provider explained how personality affects not only how providers interact with their clients, but how they engage with the idea of cultural competence and their responsibility to provide culturally competent care. She explained,

“Cultural competence means that I, I see it as meaning, that I have enough understanding and interest in the people with whom I am working or will be working that I can engage with them, um, not only working but we’re focusing on the workplace I guess, in OT, that I can engage with them with mutual respect and regard, and be able to provide them the service that I’m paid to provide. That to me is cultural competence, so that I would take the – I wouldn’t go to the textbooks and say, “what are Chinese people like in Canada?” And then come up with a generalization. But I would have enough of an intuition, and a sense of value, and ethic that I would listen to you as someone from a different place and a different culture, to myself, from myself, um… and I would see that as part of my daily responsibility,” (P12).

## 4.4. SUMMARY OF FINDINGS

 Overall, the findings of this study suggest that participants’ learning experiences and professional disciplines play a key role in shaping their understanding of cultural competence. The findings indicate that mental health care providers receive most of their education on cultural issues by choice; in other words, individuals who have not been exposed to cultural issues or who are otherwise not interested in the topic are less likely to register for relevant courses or continuing education training sessions. The findings of this study suggest that providers who are interested in cultural issues pursue learning opportunities on the topic both in school and after entering the workforce. In contrast, participants who either did not elect to take a course on cultural issues or for whom this was not an option had rarely attended continuing education sessions dedicated specifically to cultural issues.

In addition, the terminology used by each professional discipline appears to play a role in influencing how providers talk about cultural issues and how they perceive cultural competence. In addition, the terminology that participants used to describe cultural interactions reflected both their education and their beliefs about how culturally competent care can be provided. The terms “transcultural,” “cultural sensitivity,” “cultural awareness,” were each used interchangeably with “cultural competence” by participants; however, the providers used terms and definitions that were consistent with those used by peers from their respective professional disciplines.

Participants’ experience of cultural competence was impacted by personal factors, including exposure to diversity, age, and personality. Several participants credited experiences with other cultures for their interest and openness towards cultural differences. Often, exposure to diversity occurred during participants’ childhood; only because of circumstance did they gain experiences that affected their interest in cultural factors and their ability to provide culturally competent care.

# CHAPTER 5: DISCUSSION

The results of this study indicate that there is significant variation in what providers learn about cultural issues, and how that learning occurs. Moreover, while the majority of participants provided a definition of “cultural competence,” their definitions differed and largely reflected terminology that is used more frequently in their professional disciplines (i.e. transcultural, client-centered, person-centered, and culturally sensitive). Although the terms were often used as synonyms for cultural competence, each of these frameworks for working in across cultural differences has a different theoretical underpinning and carries different implications for practice. Differences in providers’ understandings of culture and cultural competence can be used as a basis from which we can better understand why discrepancies exist between the literature and how care is provided to migrant and newcomer patients in reality. The following section will discuss how providers’ learning experiences and understandings of cultural competence compare to the literature, and will explore the implications of their experiences for the quality of mental health care received by newcomer and migrant individuals.

Cultural competence has been described as a skills-based approach to delivering quality care to members of all cultural groups (Qureshi et al., 2008). In the literature, cultural competence is distinguished by its focus on skills-training and its holistic approach, which includes considering patients’ social, political, and economic contexts (Kumagai & Lypson, 2009). However, the results of this study indicate that cultural competence training has focused largely on instilling certain attitudes and teaching both transcultural and culture-specific knowledge. Meanwhile, the shift towards a skills-based paradigm does not appear to have happened as described in the literature. Similarly, while the literature describes the importance of considering social justice issues in the provision of culturally competent care, training in cultural competence does not appear to address relevant social issues. Consequently, the problems that authors have identified with cultural sensitivity and cultural awareness remain relevant despite a shift in terminology. It appears that “cultural competence” is a term that is not well understood, and that in many ways, this paradigm shift has occurred only superficially, and will significant variation across professional cultures and disciplines.

While numerous studies and reviews indicate that there is inadequate evidence that cultural competence training improves patient outcomes, (Beach et al., 2005; Bhui et al., 2007; Brach & Fraser, 2000) this study suggests that cultural competence training does have some implications for how providers interact with patients. Participants often used other terminology, such as cultural sensitivity and cultural awareness, while discussing cultural competence and other cultural issues. Providers’ continued use of out-dated terms illustrates a lack of awareness that in theory, these terms have different definitions and implications for care.

This section will discuss which aspects of the literature on cultural competence have been translated to practice, and the implications for newcomer and migrant experiences with mental health care.

## 5.1. Concepts from the literature that have been implemented in education and clinical practice

The following section discusses principles of cultural competence that are discussed in the literature and that findings from this study indicate have been translated into academic approaches and implemented in providers’ practice.

### 5.1.1. Knowledge

#### Knowledge and Use of Community Resources

An additional benefit of training in cultural competence appears to be providers’ familiarity with resources that are available for their patients and clients. Providers with training in cultural competence were more likely to be familiar with interpreter services, and as these participants were more likely to have recently attended continuing education trainings, they often appeared to feel more connected with services whose mandate is to assist newcomers and migrants. Kirmayer, Narasiah, et al. (2011) explain, “becoming familiar with existing community and religious organizations can help practitioners identify and mobilize psychosocial support and other resources when needed,” (p.964). Participants with training in either cultural competence or cultural sensitivity appeared more knowledgeable about how to access the services of an interpreter. Participants with training in cultural competence were more likely to stress the importance of using a professional interpreter rather than a family member. Several systematic reviews document improvements in mental health outcomes and increased disclosure of mental health concerns with the use of professional interpreters (Flores, 2005; Karliner, Jacobs, & Chen, 2007; Kirmayer, Narasiah, et al., 2011; Miller, Martell, & Pazdirek, 2005).

Providers with training in cultural competence often said that they would insist on the use of a professional interpreter rather than a family member, while other participants said that given the cost and lack of availability of interpreters, the use of family members was acceptable. Providers without training in cultural competence were also more likely to suggest that migrant patients either prefer to use, or “are used to” using family members as interpreter (P14; P15). Several participants with training in cultural competence described providing psychotherapy through an interpreter, and appeared more comfortable using interpreters to provide mental health care (P1; P8).

A nurse with training in cultural competence explained that her schooling included learning about how to use community resources, and provided an example of a time in which this was useful. She explained,

“[…] so helping her with just transitioning here and helping her with anything from citizenships to helping her with health care and navigating our health care here, maintaining supports and connections with her community, so for her that means through her church, because her family isn’t here, they’re back home […]” (P5).

In contrast, participants without training in cultural competence often either said that they did not know of such resources, or that they felt such resources did not exist (P2; P14).

In addition, it appears that additional training in cultural competence or related issues is often provided by community organizations. By establishing connections with these organizations, participants appear to be more informed of other training opportunities.

#### Transcultural knowledge

 The literature on cultural competence training suggests that the knowledge components of curricula should focus on transcultural, rather than culture-specific knowledge (Qureshi et al., 2008). Transcultural knowledge is described as information that is applicable across cultures, rather than information that describes elements of a specific cultural group (Qureshi et al., 2008). Participants with training in cultural competence often discussed the importance of non-verbal cues, language use, and different communication styles (P6; P10), all of which are issues highlighted in the literature (Bassey & Melluish, 2013; Leong, 1997; Lo & Fung, 2003). While participants with cultural competence training discussed learning about generalizable issues in health care, other participants often described having learned about health concerns and behaviours present among specific cultural groups. While the literature does suggest that clinicians gain some group-specific knowledge about the populations they work with (Bassey & Melluish, 2013), participants in this study often indicated that the group-specific knowledge they received in school was not relevant to the populations they worked with (P3). Overall, it appears that this type of learning has largely been replaced with learning about more generalizable issues.

### 5.1.2. Attitudes

#### Openness

Participants who took courses in cultural competence also appeared more likely than participants with training in other cultural issues or without training related to culture to ask patients or clients directly about their culture and its influence. The literature on cultural competence largely suggests taking a direct approach to learning about patients’ cultural identity and explanatory models. In an overview of principles of cultural competence, Bassey and Melluish (2013) write, “When engaging members of minority groups, it is important from the outset to attend to cultural variables while eliciting information, rather than wait for cultural issues to arise,” (p.160). Participants who had taken courses in cultural competence appear more likely to take such a direct approach (P1; P5; P8; P10). Other providers were more likely to wait for cultural issues to be raised at the patient’s discretion. These participants often indicated that they did not want to make assumptions that a person’s cultural background would be more important if they are a migrant than if they were born in Canada (P4; P9; P11).

However, several authors suggest that patients or clients may feel uncomfortable raising cultural issues in health care settings (Anderson, 1987; Kirmayer, Narasiah, et al., 2011). Anderson (1987) found that migrant women often feel their health care providers would not understand cultural issues and associated social stressors, and were hesitant to mention them during appointments. While the intention of not making assumptions about migrant patients may be admirable, in this case, providers may be missing important information about their patients’ health care beliefs and practices. Providers from disciplines that emphasize person-centeredness appeared less likely to ask their patients or clients about their culture (P4; P9; P14; P15). These providers often strongly emphasized the importance of not making any assumptions, and treating culture as just one item among many others that make up the individual. However, the providers who emphasized person-centeredness but had *also* taken a course in cultural competence appear to be able to reconcile these two ideas and were more comfortable addressing cultural differences directly (P5; P12; P13). For instance, one anecdote from an occupational therapist illustrates how the concepts of client-centeredness and cultural competence can in fact be complementary. She explained,

“Now, many ethnic families will tell you the same thing; grandma loves it when - ‘cause she’s in pain ‘cause people take care of her. Now what I’m trying to do, and I like the fact that you’re going to come and do for me, so do you think I’m crazy if I’m going to start to do all this for myself because all the attention goes away! Now I’m being a bit glib, but in reality it’s there, eh? So if that’s the case, one has to respect it. One has to say that on a client-centered level, I really understand this…however it’s not going to help your pain. So if you want to live this way, I totally understand and respect your cultural heritage. However, your pain is not going to get any better unless you do get a bit stronger or you do start to move around. So think about it and we’ll talk again,” (P13).

#### Reflexivity

Both the literature and cultural competence training stress the importance of providers’ ability to reflect on their own cultural heritage and biases (Bassey & Melluish, 2013; Kirmayer, Fung, et al., 2011; Qureshi et al., 2008). Participants who took courses in cultural competence were more likely to identify their own culture as a factor in the provision of culturally competent care. Often, these participants stated that before undergoing training in cultural competence, they had not been aware of their own cultural identity, and had considered “culture” as something that only people from other countries had (P1; P8). In addition, several participants with training in cultural competence identified biomedicine itself as a cultural construct, while this was not mentioned by participants without any such training (P5; P8; P13). For example, a mental health nurse who had received cultural competence training explained,

“Well I think there’s a lot of reflective practice there. Because I’m coming from a bias; I’m trained with a medical model, and they’re coming in maybe not being familiar with a medical model. So when I’m presenting that information, it’s really just information for them to take, to take away from it. Because maybe they don’t agree with it. Maybe they don’t agree with that model, and that’s fine too,” (P5).

Participants without training in cultural competence were more likely to explain that they felt they did not have a cultural identity (P9; P13). Several participants with training in cultural competence mentioned the fact that every individual has their own culture, and linked “culture” to ethnicity, race, nationality, sexual orientation, and socioeconomic status (P5; P8; P10). However, several participants still seemed to indicate that they understood “culture” as something belonging only to immigrant and racialized individuals. For instance, one participant said, “I don’t know, coming from my background […] I don’t feel like I have a strong cultural identity,” (P1). This participant had taken a course on cultural competence, and described the course as including a section about reflexivity. However, she explained that she continued to have difficulty recognizing the impact of her own cultural background on her practice.

#### Commitment to Lifelong Cultural Learning

Participants in this study who had experienced training in cultural competence felt they benefited from this training. In contrast, however, participants who had no training related to cultural issues often felt there would be little benefit to such training. Often, the latter group expressed the belief that cultural competence could be learned through experience, and that trainings in cultural competence would not be useful in their practice. Participants who have experienced trainings in cultural competence appear to feel that cultural considerations are something that affects their practice directly, while other participants are more likely to describe cultural considerations as only “theoretically” relevant. This distinction is especially important in the context of a society that increasingly values “evidence-based medicine” and “evidence-based practice”. Mixed evidence of the effectiveness of cultural competence training for improving patient and provider outcomes may lead to the belief that cultural competence training is not practically useful (Harmsen et al., 2005; Sequist et al., 2010; Thom et al., 2006). Beagan (2003) suggests this belief may be a major barrier to the implementation of cultural competence training programs. Several statements by providers support this idea, as many participants indicated that they had not pursued continuing education opportunities for this reason (P2; P11; P14). In fact, one participant with experience planning conferences for a psychological association explained,

“So we choose those things get a lot of attendance at conferences, [but] picking things like cross-cultural issues, I think from an education perspective and it just doesn’t draw a lot of people so they don’t offer a lot of that. So that’s certainly something that’s hard to find. And I can speak on a little bit of authority because I’m actually the president of one of the psychology associations and the head of their conference launching committee. So while there are some people who express an interest in the topic, you can’t fill a room,” (P3).

Overall, participants who had taken courses related to cultural issues appear to be more likely to attend continuing education sessions about cultural issues and keep up to date with the literature on cultural issues. However, this study is unable to ascertain whether these providers took courses on culture because they were *already* interested in cultural issues, or if their interest in continued cultural learning is a *result* of their exposure to cultural issues in an academic setting. Nevertheless, providers who took courses in cultural competence appeared for the most part to be more up-to-date in terms of their awareness of best practices for providing culturally competent care, and more aware of relevant training opportunities.

## 5.2. Concepts from the literature that have not been implemented in education or clinical practice

### 5.2.1. Skills

Despite the fact that the literature on cultural competence emphasizes the implementation of a skills-based curriculum (Bassey & Melluish, 2013; Bhui, 1999; Qureshi et al., 2008), many participants felt their education focused more on knowledge and attitudes. Participants’ descriptions of cultural competence training indicate that while the shift to “cultural competence” was intended to be a shift towards a skill-based paradigm, this change has not occurred in reality. The focus on attitudes, which is characteristic of “cultural sensitivity” training (Hutnik & Gregory, 2008), was evident among the majority of participants, including both those who had and who had not received any cultural competence training.

The skills described in the literature as being crucial for the provision of culturally competent care can be broadly categorized as intercultural communication skills, reaching a shared understanding, building therapeutic relationships, and modifying interventions (Bassey & Melluish, 2013; Qureshi et al., 2008). The following section will explore how participants understand each of these skills, and how their education addressed these areas.

#### Intercultural communication

Intercultural communication skills appear to be taught more than any other of the skills discussed in the literature. However, these sessions were not compulsory, nor were they part of professional training. As discussed earlier, several participants who had not taken courses about cultural competence felt interpreters were unnecessary or too burdensome. Despite this training being available, it appears unlikely that health care providers who are not already interested in working with interpreters would access this resource. Moreover, providers with training indicated that training focused on appreciating the value of using an interpreter rather than on how to work effectively through an interpreter (P1; P5; P10).

Several participants with intercultural communication training described the challenges associated with working with interpreters, and stressed the importance of these skills. In contrast, multiple participants who had not experienced this kind of training indicated that they felt “uncomfortable” working through interpreters and would be hesitant to see a client or patient who required the services of an interpreter (P2; P3; P10).

Moreover, even those participants who had received training in using interpreters acknowledged the difficulty of building a therapeutic relationship when using an interpreter (P5; P6). Interestingly, it appears that training in intercultural communication focuses on how to communicate information rather than how to communicate empathy. This finding is reflected in other studies that found interpreter use was associated with improved patient knowledge, but that patients were not satisfied with their relationship with their health care provider (Ngo-Metzger et al., 2007; Pugh & Vetere, 2009). The lack of training in building therapeutic relationships in cross-cultural interactions will be explored in the next section.

#### Building a Therapeutic Relationship

The development of a strong therapeutic relationship is both essential for cultural competence, and a challenge in cross-cultural interactions (David & Rhee, 1998; Diamond et al., 2009). The relationship between the clinician and patient is affected by both the individuals’ experiences and the historic relationship of their cultural groups (Bassey & Melluish, 2013). Providers must therefore be conscious not only of their own assumptions, but of those held by their patients (Bassey & Melluish, 2013). They must also be aware of the power dynamics and political contexts that shape each interaction. Intercultural communication and the modification of treatments have both been identified as skills that allow positive therapeutic relationships to develop. In addition, (Beach et al., 2006) identifies the need for providers to engage in “empathic understanding” by acknowledging their lack of knowledge and expressing to their patients’ their desire to learn more. Building a therapeutic relationship also requires trust and collaboration, both of which are hindered when clients perceive that their values and beliefs are at odds with those of their health care provider (Donnelly et al., 2011; Kleinman, 1978; Weerasinghe & Mitchell, 2007).

Participants who had received training in cultural competence appeared more aware of the importance of these considerations, and were more likely to discuss specific strategies used to develop strong therapeutic relationship in cross-cultural interactions. However, the literature suggests that to build a therapeutic relationship, clinicians must recognize the power dynamics at play in their relationships (Beach et al., 2006; Kirmayer, 2012b). The majority of participants, including those with training in cultural competence, were either unaware of these dynamics, or felt they didn’t exist. Several participants explained that although their patients might *perceive* a power difference, this kind of inequality did not play an important role in their interactions (P5; P6; P8). Despite it being present in the literature, cultural competence training appears to have largely neglected to teach clinicians about social power and how to address it. In fact, the frameworks of cultural safety and critical consciousness have emerged largely in response to the failure of cultural competence to address these issues (Gustafson & Reitmanova, 2010; Kirmayer, 2012b; NAHO, 2006). Despite participants’ attempts to engage in empathic understanding, power dynamics may therefore prevent the development of an effective therapeutic relationship. Indeed, several participants acknowledged that “perceived” power dynamics have prevented their patients from disclosing certain information or providing feedback about cultural variation (P6; P9).

#### Reaching a Shared Understanding

 While participants with training in cultural competence appeared aware of the role of explanatory models in determining how patients understand and experience their illness, there was variation in how they used this awareness and incorporated it into their practice. Despite being well-intentioned and based in an awareness of cultural variations, providers’ actions often appear to be contrary to what is recommended by the literature on cultural competence.

The literature on cultural competence stresses that providers must be skilled in “diunital reasoning,” and able to recognize the validity of different worldviews (Alberta & Wood, 2008; Bassey & Melluish, 2013). The findings of this study indicate that while many participants tolerate the beliefs of their patients or clients, they do not actually accept the beliefs as valid. Taylor (2003) stresses that culturally competent providers must accept that “real” and “cultural” are not mutually exclusive terms. However, it appears that many participants of this study could accommodate alternative beliefs and therapies, but only when used in conjunction with biomedical approaches. For example, one psychoogist described how she modified cognitive behavioural therapy to match the cultural context of a patient:

“So just things, like even in how I approach therapy for her, because her religious beliefs are very strong, so I had to modify my CBT, because if you’ve got somebody who says, like ‘because of my faith, I can get through XYZ.’ Well you can’t really say like, ‘Well that’s great, but let’s look at cognitive reframing,’ because it’s not going to work the same way. So, just in terms of being able to accept and incorporate a person’s given religious beliefs in order to make what you’re trying to teach more relevant, understandable, and to make it easier for them to apply it, and not making it like ‘my faith teaches me this, but you’re telling me that?’” (P6).

In this case, therapy is modified to meet the client’s needs, but at its core remains essentially the same. However, providers appear to have greater difficulty adapting to beliefs that directly contradict biomedical models. Several participants described instances in which they struggled to reach a shared understanding with their patients or clients, and ultimately were not able to provide further care. Without coming to a shared understanding, providers are limited in their ability to modify interventions in a way that is satisfying to both themselves and their patient, a skill that Sue (1998) calls “culture-specific expertise.”

For example, several participants provided examples of situations in which their patient had been diagnosed with a psychosis but they were unable to pursue further treatment because of differences in their interpretation of symptoms. Often in these cases, the patient or their family interpreted their symptoms differently than the provider, resulting in conflicting ideas over how to proceed with treatment, if at all. One psychologist explained that she and a patient were unable to proceed with therapy because of such a difference in their interpretation of symptoms:

“It was a student at the university who was demonstrating early signs of psychosis, and we as the team sort of supporting students at the university were trying to get supports for the student to get to where, I guess in our cultural view, to where they could function well and get back on track with the path they wanted to have in their life. And then the family culture was at odds with that. Because you didn’t *do* that. This was actually something unique and special, and we need to allow it to foster. Which is in total conflict with our sort of Western idea of how this works and how we do things. But those are some real conflicts – sometimes you have these conflicts that you just can’t resolve,” (P10).

In a similar example, a nurse explained how despite the fact that the patient’s treatment did not continue, this was still an example of providing culturally appropriate care.

“Here was a young man, a youth, probably like 17 or 18 years old, left home – was living in Toronto and left home. He was staying at a shelter, and this is when I was involved with homeless shelters and involved with working with street youth – he had psychosis, he had psychotic disorder so we were trying to get him connected with an early intervention clinic and trying to get him reconnected to his family, his parents, so his parents came down and they felt that he had a spirit inside of him, and that he wasn’t ill and it wasn’t a psychotic disorder. We had to apply some of those skills that we learned in class – so the person’s readiness and the supports that they want and the supports that they don’t want. And they weren’t willing to explore the supports through our Westernized medicine and they wanted to support him in their culture, and so they had a lot of – they were going to get involved with their priest, and they took him home,” (P5).

In both of these cases, participants described a divide between “Western” and “cultural” beliefs. This indicates difficulty in coming to a shared understanding, and suggests that what is “cultural” is not perceived by providers as being “real.” This kind of discourse is reflective of a more problematic perception that culture is a challenge to be overcome. Anderson (1998) explains that cultural *sensitivity* aims to understand alternative perspectives and have patients comply with Western health care practices. In contrast, the literature on cultural *competence* suggests that providers should accept explanatory models outside the biomedical paradigm as valid (Taylor, 2003). However, it appears that in practice, clinicians’ perceptions of cultural competence are more representative of culturally sensitivity.

#### Incorporating Congruent Strategies and Goals

It appears that due to the absence of skills training, providers are left with knowledge about common variations in patients’ experiences, but with no guidance in how to use that information. The ways providers use their cultural awareness appears to vary in line with their professional discipline, and the framework that each discipline uses to understand cultural issues. For instance, providers with a background in transcultural psychiatry may focus on considering whether a diagnosis is culturally sound, while participants with cultural sensitivity training described focusing on making the intervention more palatable to patients from a different cultural background. However, these approaches are not always congruent with cultural competence. For instance, on psychologist explained,

“So if the client were to say, you now, I see or hear the ghost of my aunt speaking to me… that is a cultural norm. So we can’t apply, you know, western thoughts, like ‘Oh, really, you see ghosts?’ I mean, depending how you look at it right, I mean if you’re in a setting and somebody says something like I’m seeing ghosts, and then you think about things like, oh, does this person have a psychosis, do they have schizophrenia, is there something going on with this person? But depending on their background, that might just be a cultural norm, right, that we would approach differently,” (P8).

This approach is consistent with the literature on transcultural psychiatry, which suggests modifying diagnostic criteria in cross-cultural encounters, and emphasizes the meaning and context of patients’ illnesses (Bhui, 1999; Kleinman, 1980; Kleinman & Benson, 2006). However, the literature on cultural competence cautions against assuming that phenomena with cultural meaning cannot also be problematic or indicative of disease, and emphasizes the need to assess the degree to which “symptoms” are culturally influenced (Bassey & Melluish, 2013; Puri, 2005; Sue, 1998).

 In addition, this approach may be problematic because it can encourage stereotyping, and can potentially lead to misdiagnoses or the under-diagnosis of certain diseases among various cultural groups. Cultural competence is supposed to shift health care providers away from frameworks that encourage them to view patients as members of ethnic or cultural groups rather than as individuals (Beach et al., 2006). Sue (1998) emphasizes the importance of “scientific-mindedness” to test hypotheses about cultural groups. It appears that without this skill, providers’ hypotheses instead form the basis for assumptions on which they base their diagnoses and treatment. Interestingly, some providers discussed the need for training in this area. One psychologist explained,

“I think they need to basically you know have something that’s about – you know, like how to assess cultural differences, whether they’re there or not, and how do you acquire that knowledge. Rather than, like here’s a list of different cultures and here’s what they do. Because I think that that’s something that’s been done before,” (P3).

 Indeed, assessing cultural differences and the degree to which they are relevant has been noted by the literature as an important skill. Puri (2005) cautions that South-Asian women often feel evaluated more based on their culture than on their health care needs. She questions, “In endless attempts to remove assumptions from clinical encounters, why are we increasing the number of assumptions?” (Puri, 2005). Several participants discussed the importance of patient-centered care and human-centered care in arguing that providers should not assume that cultural variations are relevant (P4; P9; P15). In contrast, Alegria et al. (2010) point out that culture is by definition not an individual construct; it is shaped by the environment in which individuals interact and exist. Failing to consider this context may lead health care providers to miss salient aspects of their patients’ experiences.

Teaching providers how to modify interventions is especially important given that several studies suggest that patients are less likely to comply with treatment when they do not agree with the intervention or the diagnosis (Donnelly et al., 2011; Kleinman et al., 2006). However, incorporating “alternative” treatments can be difficult given the focus of health care institutions on evidence-based practice. One psychologist described an incident that clearly illustrates how cultural competence and evidence-based practice can conflict:

“We had a client who was from a remote northern Native American reserve. And he had come to the hospital because he believed that he had been cursed by – and that he was going to die – because demons were out to get him. And they treated this gentleman for many years at different hospitals as if he was a schizophrenic. But the reality was that he had actually been cursed by someone. So there was basically a medicine-man, a shaman sort of, from his tribe, who was upset with him for some reason and who basically cursed him, and told him, you know, ‘I put these demons and devils on you, and they’re going to hunt you until you die.’ And he was pretty distraught by that, being a person who is you know, a believer of kind of the traditional belief system of his type of tribe. And the – we had a doctor who decided to actually bring in another religious leader from a nearby religious tribe who was considered like the strongest one in the region. And he removed the curse, and the guy was fine. It actually cured him. He’d been given medication for years, and this resolved the issue. But the psychiatrist and the psychologist who brought the guy in got in trouble. Because they – they got in trouble with administration of the hospital because they considered it – the hospital actually perceived it as being culturally insensitive, and that they were making fun of this guy. […] I think that if you did that now – like if I brought in a shaman to relieve someone’s curse, I would get in trouble […] I would get in trouble from the hospital, I think that I would be like at risk of getting in trouble with the College of Psychologists, because they’ll turn around and say, you know there’s a requirement in psychology that we are only allowed to use treatments that have been scientifically validated as working,” (P3).

This case illustrates how the focus on using evidence-based interventions can discourage providers from using alternative therapies, despite the fact that the latter may be more effective for certain patients. The conflict between evidence-based practice and cultural competence is complex, and involves actors at multiple levels of the health care system. The intention of evidence-based medicine is that interventions should be applicable universally (Aisenberg, 2008). However, the context in which this knowledge is produced is largely ignored. Clinical trials often disproportionately include white males in their samples, and the findings are often generalized despite evidence that environmental and biological variations play and important role in determining individuals’ response to treatment (Aisenberg, 2008; Kirmayer, 2012a). In addition, the biomedical model (and evidence-based practice) largely conflates “culture” with ethno-racial identity, ignoring the ways in which culture is constructed (Kirmayer, 2012a). In contrast, cultural competence demands an examination of this social context, and condemns the stereotyping that emerges from research that produces conclusions about specific “cultural” groups (Kirmayer, 2012a).

Both the literature and cultural competence training need to clarify how clinicians should negotiate these two paradigms. Without such clarification, health care providers are left unsure about what they should do, and what they are allowed to do. For instance, while some authors stress the importance of acknowledging and incorporating other explanatory models (Taylor, 2003), others focus on the importance of providers maintaining a sense of integrity and providing treatments they believe will work (Qureshi et al., 2008). Overall, both the literature and cultural competence training appear to give only vague recommendations for how providers should modify interventions. (Qureshi et al., 2008) write, “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.” It appears that clinicians are largely left to figure out these limits on their own, with little guidance as to how to modify treatment plans and interventions, and to what extent they should be flexible.

### 5.2.2. Social Justice and Discrimination

The literature on cultural competence emphasizes that providers must recognize the social position and conditions in which they and their patients exist (Chiu et al., 2005; Donnelly et al., 2011; Kleinman, 1978, 1980; O'Mahony & Donnelly, 2007a; Stephenson, 1995). The emphasis on social justice is one of the facets of cultural competence that, in theory, differentiates it from its predecessor. Kumagai and Lypson (2009) point out that the LCME directive on cultural competence explicitly addresses the need to teach clinicians about gender and cultural biases in health care. However, it appears that this aspect of the directive has been largely ignored in clinical training. In a study of cultural competence training programs, (Beach et al., 2005) found that only two of the thirty-four curricula addressed discrimination and racism. Similarly, Beagan (2003) found that training in cultural competence improved medical students’ knowledge of disadvantages suffered by certain populations, but that students remained largely unaware of the privileges enjoyed by members of dominant groups.

The findings of this study suggest that the majority of mental health care providers do not feel these factors are especially relevant to their work. However, evidence suggests that experiences of racism and discrimination are associated with elevated incidence of mental illness (Kirmayer, Narasiah, et al., 2011; Noh & Kaspar, 2003). Only one participant mentioned racism (P13), and while social workers were more likely to raise the issue of discrimination, this was largely in the context of discussions about issues on First Nations reservations (P4; P9). Similarly, despite the fact that economic marginalization and poverty have been linked to both newcomer status and increased risk of mental illness, participants rarely mentioned these factors when discussing their work and the challenges facing newcomer populations (Beiser, 2005; Reitmanova & Gustafson, 2009).

While some participants discussed disparity in migrant and newcomer access to mental health services, this was often presented as factual information rather than as a problem. For instance, one psychologist explained that he rarely saw immigrant patients, saying,

“People who are like immediate immigrants, meaning not second generation, they would come across our door, but not at the same level of frequency. More likely I would come across them in the hospital or university sectors where we will get people who are paid for by third party. But a lot of like, recent immigrants don’t access private mental health,” (P3).

As in this example, many participants seemed aware that newcomers disproportionately access walk-in clinics and emergency room departments for health care concerns. However, none of the participants indicated that this constitutes discrimination or contributes negatively to patient health, despite the fact that patients may experience disjointed care and long wait-times when seeking care at community health centres, walk-in clinics, and emergency room departments (Asanin & Wilson, 2008; McKeary & Newbold, 2010).

Several authors suggest that providers’ refusal to accept newcomer patients contradicts the principles of equitable health care access and delivery, and may constitute a form of institutional and systematic discrimination (Asanin & Wilson, 2008; Johnson et al., 2004; McKeary & Newbold, 2010). However, participants in this study felt their refusal to accept newcomer patients was a form of reflexive practice, and an appropriate response in recognition of their limitations. Participants did not seem to consider this a barrier to accessing care, nor did they seem to think that patients would consider this discriminatory. Similarly, several participants acknowledged that newcomer patients required more appointments in order to find an effective treatment plan or to be satisfied with their health care (P3; P14). Some participants mentioned the cost incurred by the *provider* when appointments took more time or when patients returned frequently (P14). While some participants acknowledged the additional cost incurred by patients, they did not frame this as a form of discrimination or inequity.

Similarly, participants appeared largely unaware of the structural constraints that affect their patients’ ability to seek care and manage their illness. For example, one participant explained,

“Well as a group unfortunately, there’s been a lot of problems with missed appointments, missed appointments with specialists, with myself… I can’t explain why that is […] So it’s a little frustrating, that when you try really hard to set something up for them, and try and take a lot of time to learn about their issues, and then they… somehow just don’t take your advice. Not that everyone takes my advice anyway. But, when I’m particularly concerned about somebody and I…. I… have the expectation that they are going to follow through and I make sure that they follow through… but with these guys, I can’t.” (P14).

Participants were often frustrated with patients’ lack of compliance and follow-up.

In general, however, participants did not appear to link these issues to larger, structural problems. Instead, they were interpreted as “cultural norms.” This indicates that providers may not be adequately trained to recognize the structural constraints their patients face, including the transportation issues and costs that may impede their ability to seek care. For instance, Edge and Newbold (2013) describe how as a consequence of language barriers and reliance on family members, finding reliable transportation becomes an obstacle that can hinder newcomer access to health care services. Many newcomer and migrant patients rely on family members to provide transportation to appointments (Chin, 2000). However, these arrangements can be unreliable, and increase the cost of appointments as both the patient and the driver may be taking time off work (Chin, 2000). The inability to take time off of work has also been documented as a barrier to seeking care (Donnelly et al., 2011; Kirmayer, Narasiah, et al., 2011).

Similarly, some participants were frustrated with language barriers and expressed the perception that migrant patients were not interested in learning English. However, the barriers that impede newcomers, especially women, from learning languages are well-documented. Several studies indicate that immigrants, especially women, encounter several barriers in learning languages, including illiteracy and difficulty finding time while balancing work and caring for their families (Anderson, 1987; Chiu et al., 2005). In addition, Oxman-Martinez et al. (2005) highlight the fact that many women are sponsored immigrants and are therefore less likely to have a grasp on either official language. For these women, social isolation, lack of language skills, and minority status intersect and impede their ability to access language training and, consequently, health care services (Oxman-Martinez et al., 2005). Some participants, however, appeared frustrated with their patients’ “choice” to not learn English. For instance, one physician explained,

“Because although there are many patients I have to say in my practice, like the Afghanis, who even though they’ve been here for ten years, they still have no knowledge of English, don’t desire to speak English, don’t have any contact with anyone outside their Afghani families or members of the community, so they are very isolated,” (P14).

In this case, both patients’ isolation and inability to speak English were perceived as a choice rather than a consequence of their social position.

While social workers and occupational therapists mentioned the need to learn about the diverse challenges that their clients face, the findings of this study suggest that in general, mental health care providers rarely address these issues unless their clients or patients explicitly mention them during a consultation. However, as social position and structural constraints have been shown to shape both patients’ health and help-seeking behaviours (Donnelly et al., 2011; Dyck, 1995; Lynam, 2007; Newbold, Cho, & McKeary, 2013). By failing to recognize social constraints and stressors, there is a risk that providers may over-pathologize and misdiagnose normal responses to stress (Edge & Newbold, 2013). In addition, providers may be less able to empathize with their patients, and their consequent frustration may strain their therapeutic relationships. In addition, by interpreting issues with non-compliance and timeliness as “cultural norms,” clinicians inadvertently contribute to the stereotypes that discourage providers from taking on newcomer patients, and that can lead to further marginalization (Johnson et al., 2004). By overemphasizing the role of culture in patients’ help-seeking and illness management, the role of structural factors is obscured (Lynam, 2007).

Anderson (1998) argues that providers should play a role in advocating for their patients, and that by failing to do so, providers accept inadequate resources and are complicit in reproducing the institutional problems that lead to cultural incompetence and unequal care. Several providers did describe advocating for their patients in terms of helping them to access school resources. However, when it came to a lack of health care resources, such as interpreter services, the majority of providers indicated that this was out of their control and beyond the scope of their practice.

### 5.2.3. Cultural Humility

 The literature also stresses the importance of cultural humility, and the understanding that cultural competence can never fully be achieved (Bassey & Melluish, 2013; Qureshi & Collazos, 2005). Qureshi et al. (2008) write, “A potential danger in competency models is the notion that mastery is possible, such that one can indeed be an culturally competent clinician.” However, it appears that cultural humility is not taught as a component of cultural competence. Rather, participants who discussed cultural humility often understood it as an alternative, contradicting framework, or as a reason why cultural competence is an unrealistic concept. They suggested that the absence of cultural humility was not evidence of poor teaching of cultural competence, but rather an indication that cultural competence is incompatible with cultural humility. Similarly, several authors portray cultural competence and cultural humility as distinct paradigms (Gustafson & Reitmanova, 2010; Tervalon & Murray-García, 1998). In contrast, none of the participants with specific cultural training used the term “cultural humility,” indicating that this concept may be absent from training in cultural competence. In fact, several participants conflated cultural competence with licensing competencies, and as something that one could become competent in (P6; P10). The interpretation of “cultural competence” as an achievable goal contradicts the principles of cultural humility. Tervalon and Murray-García (1998) state, “cultural competence in clinical practice is best defined not by a discrete endpoint but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves.”

An important component of cultural humility and reflexivity is providers’ ability to recognize their own limitations (Donnelly et al., 2011; Teng et al., 2007). Regardless of training, the majority of participants appeared to recognize their limitations and the limitations of their ability to “know” other cultures. Several participants acknowledged the limits of what could be taught in a course. While providers did discuss engaging in reflexive practice and being aware of the limitations of their ability to provide care for patients outside their own cultural group, how providers described using this awareness conflicted with the principles of cultural competence and cultural humility. The literature on cultural humility suggests that providers engage in life-long learning to better understand the dynamics of culture (Tervalon & Murray-García, 1998). However, many providers were aware of their limitations and felt they should simply accept that they could only provide care to patients for whom culture was “not relevant” (P2; P3).

## 5.3. Implications

Overall, mental health care providers continue to consider cultural differences an important facet of their interactions, but approach these differences from a perspective that is more consistent with cultural sensitivity than with cultural competence. While it is commendable that mental health care providers do often make an effort to provide culturally appropriate care, the lack of cultural competence training has negative implications for the quality of care received by newcomer patients as well as for newcomers’ ability to access health care systems. In addition, the discursive practices consistent with cultural sensitivity are different from those promoted by the literature on cultural competence, and have important implications for newcomer and migrant individuals.

### 5.3.1. Quality of care

The shift to a skills-based paradigm should, in theory, alleviate several concerns related to the quality of care received by migrant and newcomer patients. However, due to the fact that education has largely neglected the skills component of cultural competence, these goals have not been realized.

First of all, mental health care providers may be more likely to misdiagnose illnesses among migrant and newcomer patients. Both the lack of training in how to assess cultural variation and its relevance as well as the lack of education on social factors contribute to this problem. Misdiagnosis may occur when providers either do not know about culturally mediated signs of distress, or when they do not know how to respond to these signs. Although some participants felt these signs could be learned through experience rather than in a classroom setting, they also acknowledged that early in their practice they would not have recognized these symptoms as signs of mental distress (P14; P15). Similarly, in a study of depression among South Asian patients in the United Kingdom, Bhui et al. (2007) concluded that the prevalence of depression appeared lower among South Asian patients because of symptom presentation that was not consistent with what is described in diagnostic criteria. In order to give a correct diagnosis, it is essential that providers have the skills to discern when this knowledge is generalizable, and how to explore individuals’ cultural context (O'Mahony & Donnelly, 2007b; Sue et al., 1992). Without this skill, providers will either fail to consider cultural factors, or are more likely to engage in stereotyping, which has been associated with significant health consequences (Johnson et al., 2004; Noh & Kaspar, 2003).

Misdiagnosis can also occur when providers ignore the role of post-migration stressors and individuals’ social position. When providers fail to consider these important factors, they may medicalize normal responses to stress (Edge & Newbold, 2013). Social processes, such as racism and discrimination, can play a role in elevated incidence of mental illness (Kirmayer, Narasiah, et al., 2011; Noh & Kaspar, 2003). By failing to consider these factors, providers miss important opportunities to recognize these problems and help their patients to develop coping strategies.

The quality of care received by migrant and newcomer patients is also negatively impacted when patients receive unequal treatment. This may occur when providers make assumptions about the kind of treatment their patients want based on cultural stereotypes, and focus too much on cultural adaptation rather than on providing effective treatments (Kirmayer, 2012a). For instance, providers often assume that counselling or talk-therapy is not culturally appropriate; however, Donnelly et al. (2011) found that immigrant women did benefit from counselling services. It is important to recognize that what providers may perceive as “culturally appropriate” may be perceived by patients as discrimination (Edge & Newbold, 2013). For this reason, it is crucial that providers are able to communicate openly and clearly with their patients about their cultural needs and understanding of their illness.

 In addition, some participants described instances in which their patients could not continue treatment because of opposition from other family members (P5; P10; P13). They indicated that in an effort to be respectful of the family’s cultural beliefs, they could not encourage them to continue treatment. However, O'Mahony and Donnelly (2007b) raise the concern that families often try to conceal women’s illnesses and limit their access to treatment. Similarly, Neale and Wand (2013) suggest that families often encourage relatives to conceal or deny mental health problems because of the perception that mental illnesses are personal or moral problems. It is important to question in this case whether providers may be reproducing the unequal treatment of these patients on the grounds of respecting their culture. Puri (2005) cautions against compromising patients’ rights in the name of multiculturalism, writing that the danger of culturally sensitive practice is its ability to reduce a patient

“to his or her religious, ethnic or cultural background, and providing medical care in accordance with the limitations that physicians believe a patient’s background imposes. Such an approach also homogenizes members of these different ethnic, religious and cultural groups, reducing them to a set of common behaviours that they all supposedly practice, and giving primacy to the characteristics of the group, characteristics that are defined primarily by only a handful of individuals and that do not recognize power relationships within communities or communities’ very heterogeneity,” (Puri, 2005).

Newcomer patients may also receive unequal treatment as a result of structural constraints. For instance, although the length of an appointment may be the same, the use of an interpreter and the need to assess salient cultural factors may take up additional time. Consequently, migrant patients may not have time to ask questions about their treatment plan, or may feel rushed and dissatisfied with their care (Bhui, 1999; Bhui et al., 2007; Donnelly et al., 2011). This has detrimental impacts for patient health, as noncompliance with prescriptions can be a result of not understanding medications (O'Mahony & Donnelly, 2007a).

### 5.3.2. Access to care

While the fear of encountering cultural incompetence is itself a barrier to accessing health care, cultural incompetence can impact migrants’ access to health care services in other ways (Asanin & Wilson, 2008; Edge & Newbold, 2013; O'Mahony & Donnelly, 2007a). Cultural incompetence can contribute to communication barriers, financial barriers, and attitudes that prevent providers from accepting newcomer or migrant patients. In addition, culturally incompetent care has negative impacts on patients’ access to care because of its role in determining patient satisfaction.

Cultural incompetence can have detrimental impacts on the communication between providers and patients. Using an interpreter always requires additional time; however, without training in using interpreters, additional errors in translation can take up time and contribute to frustration. Several studies have found that immigrant patients are disproportionately unsatisfied with their health care providers because they feel rushed and that their concerns have been dismissed (Bhui, 1999; Bhui et al., 2007; Brach & Fraser, 2000; David & Rhee, 1998; Whitley, Kirmayer, & Groleau, 2006). As poor communication wastes time and may distort patients’ concerns, dissatisfaction with health care services can occur as a consequence of the lack of intercultural communication training. This is especially worrisome as patient dissatisfaction can lead to non-compliance and can also impact future help-seeking behaviours (Bhui et al., 2001; Donnelly et al., 2011). Improvements in communication training could potentially help to alleviate some of these issues.

In fact, many participants without training in intercultural communication would refuse to take on non-English speaking patients, and would either refer them to a provider with experience using an interpreter or to a provider from a similar linguistic background. Some participants also had examples of instances in which they used listservs and communication boards to try to find mental health care professionals who could provide services in certain languages, but had no success in doing so (P3; P10). In these cases, they often referred those patients to other providers where interpreters were used. While it is important for providers to recognize their limitations, this situation illustrates the additional time and resources that newcomer patients must spend trying to find a health care provider. It appears that in this case providers’ awareness of their limitations are leading not to improved care, but to a reluctance to provide care for non-English speaking patients, thereby creating an additional barrier to access. The literature on interpreter services suggests that training for clinicians in the use of interpreters could improve both the experiences of patients and providers (Tribe & Lane, 2009). As interpreter use has been associated with improved patient satisfaction, quality of care, and outcomes (Baker, Parker, Williams, Coates, & Pitkin, 1996; Flores, 2005; Harmsen et al., 2005), increasing providers’ confidence in working with interpreters is an important, albeit neglected, aspect of cultural competence.

The additional time to deliver health care services can also create financial barriers to access, as patients (and often the family members who are acting as drivers and interpreters) must take more time off work (Chin, 2000). Unfortunately, it is also the most economically disadvantaged individuals who are the most likely to require care for mental illness (Beiser, 2005).

This study also suggests that providers are reluctant to take on newcomer and migrant patients, both because of the additional time necessary to provide care, and because of the perception that it is impossible to provide quality care for patients from a different cultural background. These individuals then need to spend more time and resources looking for a provider. This reluctance may contribute to migrant patients’ over-reliance on community health centres, walk-in clinics, and emergency rooms, where patients must endure long wait-times and disjointed care (Newbold & Willinsky, 2009).

In recognition of their limited ability to provide care for patients from other cultural backgrounds, several participants mentioned engaging in “ethnic matching,” or shifting their patient to a colleague from a similar cultural background (P2; P3). Others explained that they simply would not accept patients where cultural issues were important. Although none of the participants with cultural competence training mentioned refusing to see a patient because of cultural barriers, several said that they would engage in ethnic matching whenever possible (P8; P12).

Participants described several benefits of being from the same ethnic background as their patient, including the ease of rapport building and understanding the “nuances” of language (P7; P8). While several studies have shown that ethnic matching and language concordance can be beneficial for help-seeking and therapeutic relationships (Asanin & Wilson, 2008; Fung & Renata, 2007; Ngo-Metzger et al., 2007), this strategy can be problematic when clinicians assume that patients prefer providers from the same ethnic group. In fact, studies have found that patients often prefer seeing a provider from outside their cultural group because of confidentiality concerns in small cultural communities (Puri, 2005; Teng et al., 2007; Tseng, 1999). Ethnic matching may also be problematic in that it can emphasize the importance of racial and cultural identities above other concerns (Tseng, 1999). (Ganesan, Mok, & McKenna, 2011) explain that “cognitive match,” or congruence in the provider and the patient’s expectations, is more important for health outcomes than an ethnic match. Similarly, Sue and Zane (2009) stress that ethnic factors are less important in the development of a therapeutic relationship than a match in attitudes, values, and perception. Certainly, participants described experiences that illustrate the benefits of ethnic matching and language concordance. One participant provided a particularly illustrative example:

“So you know I’ve had women at this clinic here, this was a case, a very difficult case, she was from the Middle East and when I ask them a colleague of mine, from the Middle East, a professor here at McMaster to see her, and she did better. Because she was able to understand the cultural aspect of it that I felt could have been playing a role but didn’t know how to address it. […] So she is a patient, she came here post-partum like many of the moms we see here, and with a quote-unquote depression. And then her depression wasn’t really responding to the treatment. […] And then when I sent her to my colleague, my colleague gave me feedback that she was experiencing psychotic symptoms. She was psychotic! But she couldn’t convey that to us, and her husband, he never told us. Like no matter what way we interviewed, and we always ask questions – we ask everything, and psychotic symptoms is part of our assessment, so we did ask them, several times, but their answer was always a no,” (P2).

Although in this case, the patient clearly benefited from ethnic matching and language concordance, it would nevertheless be a mistake to assume that ethnic matching is always appropriate, or that it is a suitable alternative to developing cultural competence.

While providers may perceive their refusal to accept migrant or non-English speaking patients as a way of ensuring these patients find a provider that can meet their needs, this is contributes to unequal access to health care for certain residents of Canada, and is a form of systemic and institutional discrimination (Edge & Newbold, 2013; Johnson et al., 2004). Providers’ lack of confidence in their ability to provide culturally competent care thereby impedes migrant and newcomer access to health care.

### 5.3.3. Discursive impacts

The ways in which health care providers learn about culture and implement these ideas have important implications for how culture is addressed more broadly in health care systems. The findings of this study indicate that mental health care providers largely implement concepts that are congruent with cultural sensitivity, or with aiming to provide treatment in a way that is meaningful and effective for patients from different cultural groups (Watters, 2001). However, this paradigm fails to consider the interaction between cultural and social groups, and can homogenize cultures and the lived experiences of members of those cultural groups (Johnson et al., 2004). While the social sciences appear to play a greater role in mental health care providers’ education, it is largely as a source of additional facts about cultural groups, and there has not been a change towards thinking about culture as socially constructed. Consequently, cultural barriers continue to be perceived as problems residing within the patient, rather than a consequence of interactions between cultural systems (Anderson, 1987). Thinking about “cultures” as knowable, static entities allows providers to consider cultural factors without client input, which leads to stereotyping and making assumptions about how patients experience health and health care (Gustafson & Reitmanova, 2010; Puri, 2005).

In addition, the findings of this study suggest that providers largely continue to think about culture as something that they themselves do not experience. Culture is then understood in terms of categories that legitimate one at the expense of the other; while “Canadian” culture is normalized, the cultures of the Other are problematized and constructed as challenges to be overcome (Anderson, 1998; Dutta, 2007; Park, 2005). For instance, when providers stereotype all members of a specific cultural group as being noncompliant or “difficult,” they reflect and enforce the ideologies and values associated with the dominant or mainstream cultural group (Aldwin, 1994; Anderson et al., 1991; Donnelly et al., 2011; Filipp & Klauer, 1990). Moreover, by stereotyping these problems as “cultural norms,” providers may also contribute to the masking of social processes that marginalize migrant individuals (Dyck, 1995; Lynam, 2007).

Moreover, as argued by Johnson et al. (2004) and by Lynam (2007), there are significant health consequences associated with Othering processes and marginalization. It is important that providers are equipped with the knowledge of social issues and the skills to explore the complexities of patients’ needs and experiences. Otherwise, cultural factors are either not considered, or are assumed to be true without patient input.

## 5.4. Recommendations

Cultural competence requires the implementation of congruent behaviours that come together at all levels of health care systems. Consequently, although this study focused on cultural competence at the clinical level, its recommendations address the other levels of health care systems.

### 5.4.1. Clinical education

It is important that the recommendations made in the literature be implemented in practice. The findings of this study suggest that despite these issues being addressed in the literature, providers are not taught about the importance of individuals’ social position and context, and about the structural constraints that impact migrants’ ability to access health care and manage their illnesses. Training in cultural competence should equip health care providers with improved knowledge and attitudinal competencies necessary to address social and cultural barriers to care and address structural injustices that contribute to poor health (Edge & Newbold, 2013; McKeary & Newbold, 2010). A lack of knowledge of sociocultural influences may prevent providers from recognizing non-biological influences on health, thereby leading them to over-pathologize normal responses to emotional or sociocultural stresses (Edge & Newbold, 2013). The failure to acknowledge the influence of societal inequities may even cause the provider to reproduce these discrepancies (Pedersen, 2001). In addition, education continues to focus on teaching facts about culture rather than teaching the skills necessary to assess and integrate cultural factors. Cultural competence training should emphasize the importance of applying these skills to explore patients’ cultural context in partnership with each individual. By focusing on teaching *skills* related to the assessment of cultural needs, providers should in theory be able to explore and understand patients’ cultural needs and incorporate them into treatment plans without making unnecessary assumptions. The findings of this study also suggest that some providers lack confidence in their ability to provide care in cross-cultural interactions. Numerous evaluations of cultural competence training programs have found that training has positive effects on providers’ perception of their ability to provide care (Carter et al., 2006; Crandall, George, Marion, & Davis, 2004; Dogra, 2001; Gany & de Bocanegra, 1996; Hansen, 2002; Hutnik & Gregory, 2008; Majumdar et al., 2004; Owiti et al., 2013; Tang et al., 2002). This suggests that improvements in current approaches to teaching cultural competence could lead providers to feel more confident and willing to take patients from a different cultural background than their own. This is especially important, as the findings of this study suggest that some providers may be refusing patients from other cultural backgrounds because of concerns about their own limitations.

 In addition, training in cultural competence has remained largely elective. The findings of this study suggest that mandating that students take a course specifically dedicated to cultural issues may encourage providers to engaging in lifelong learning related to cultural competence. In fact, several participants suggested that cultural competence training should be made mandatory (P1; P3; P5; P8; P10).

Finally, providers’ education continues to emphasize the importance of evidence-based medicine, which claims to produce neutral, generalizable knowledge, and can lead to stereotyping (Kirmayer, 2012a). There is a need to consider the construction of culture, which conflicts with evidence-based medicine’s conflation of culture with ethnicity, nationality, and language (Kleinman & Benson, 2006). The over-emphasis of these characteristics may lead providers to subscribe to certain stereotypes and blame patients for their circumstances rather than addressing social, economic, and political inequities that remain unrecognized because they lie outside the realm of biomedicine (Collins & Arthur, 2007; Pedersen, 2001). It is important that professional training teaches providers to reconcile these competing epistemologies and recognize the advantages and disadvantages of each. Otherwise, the use of cultural stereotypes and inferior delivery of care is not only culturally incompetent: it is discriminatory and can reproduce racial and ethnic health disparities.

### 5.4.2. Structural changes

The findings of this study also indicate a need to address the structure of health care systems, as suggested by other studies’ findings (Alegria et al., 2010; Kirmayer, 2012a, 2012b). The health care system appears largely unresponsive to the unique health care needs of migrant and newcomer individuals. Guidelines for cultural competence often appear to focus on convincing providers of the importance of certain behaviours while assuming that recommendations can be implemented with structural support. However, it is necessary to address both professional attitudes and structural constraints. For instance, some participants in this study said that they would use professional interpreters if it weren’t for the lack of funding (P14; P15). Additional funding for cultural brokering services and for interpreting services is crucial if the Canadian health care system is to be made more culturally competent.

 Some participants also suggested that health care funding should take into account the additional time necessary to provide care through an interpreter or to take cultural variation into consideration (P14; P15). These participants felt that additional funding could relieve the financial burden on providers and patients, and could prevent providers from being reluctant to take on migrant or newcomer patients.

### 5.4.3. Further Research

 This study represents only the experience of a small number of mental health care providers. Further research is necessary to better understand the experiences of both mental health care providers and health care providers in general. Additional research is also necessary to understand the impact of culturally competent behaviours on patient health outcomes. A significant portion of the existing literature (including this study) focuses on understanding cultural competence from the perspective of health care providers, while omitting the experiences of the patients themselves.

## 5.5. Study limitations

There are several important limitations to this study. First of all, while the study focused on cultural competence in the provision of health to migrant and newcomer patients, the perspectives of these patients are missing. Due to the vulnerability of this population, the decision was made to focus on the perspectives and experiences of health care providers. However, patients’ perspectives are important in understanding how providers’ actions actually impact patient care and health outcomes.

 Secondly, the study is subject to significant volunteer bias. It is likely that many participants agreed to participate in the study because of a pre-existing interest in the role of cultural factors in mental health care. This is represented in the fact that many participants mentioned that they perceived themselves as being more culturally aware or culturally competent than their peers. The sample is also subject to biases because recruitment was conducted using purposeful and snowball sampling techniques. Initial recruitment emails were sent using contact information found online, and additional recruitment was conducted using contact information provided by other participants. Several participants therefore work in the same clinics and/or hospitals, and may have similar experiences and perspectives. In addition, the sample size was small, and maximum variation sampling was employed. Consequently, only a small number of providers from each discipline were represented in the study, and their statements and experiences are not necessarily generalizable.

 Social desirability bias may also have affected the results of this study, as providers may have tended to answer questions in a way they felt would be viewed favourably.

## 5.6. Concluding remarks

 Overall, the findings of this study indicate that there are significant discrepancies between cultural competence as described in the literature, and cultural competence as it is experienced and understood by health care providers. Providers’ definitions of cultural competence often omitted elements that are identified in the literature as being the core principles of cultural competence. The skills-based paradigm, cultural humility, and social justice considerations are largely what made cultural competence an improvement over previous frameworks. It appears that many providers revert back to older, more familiar terminology, and assume that cultural competence is simply a more modern term with the same overall meaning. As different training programs and disciplines teach students to consider culture in different ways, providers appear to assume they are talking about the same thing, when in reality each individual has interpreted “cultural competence” differently. The literature and recommendations for the provision of culturally competent care are rarely reflected in the experiences of mental health care providers; instead, their experiences reflect other, related concepts. There is consequently significant variation in the methods used by mental health care providers to provide what they perceive to be culturally competent care.

While this study raises some concerns about discrepancies in how cultural competence is taught and understood, it also highlights the fact that many health care providers are aware of the influence of culture in health, and are doing their best to provide care to an increasingly multicultural population. However, without changes to the way cultural competence is understood and implemented, this paradigm for providing cross-cultural care will continue to be simply an extension of previous paradigms in which “experts” are left to define cultures and reduce complex cultural realities to what is deemed “clinically relevant.” Cultural competence is then a disempowering exercise, as it renders social injustices invisible, and constructs culture as a barrier to be overcome. By failing to equip providers with the skills to determine when cultural factors are at play, cultures are essentialized and reduced to stereotypes. “Culture” then becomes a new racism; cultures are portrayed as static and homogeneous factors that prevent minority populations from receiving the same quality of care as individuals who belong to the mainstream population.

 This study raises several important questions about multiculturalism and health care: how can cultural differences be addressed in ways that are empowering, rather than marginalizing? To what extent should providers be asked to modify their practice to accommodate cultural difference? How can providers be confident in their cross-cultural interactions while recognizing their limitations as individuals with their own cultural heritage? What standards should govern the inclusion of cultural competence training across health care disciplines and academic institutions? Often, the literature is ambiguous in answering these questions, and the reality on the ground is even more confusing. If the Canadian health care system is to be made culturally competent, these issues must be addressed and solutions implemented at all levels of health care. Without improvements, “cultural competence” will simply be a new name for out-of-date methods of providing multicultural care, and newcomers and migrants will continue to experience marginalization and unequal access to quality health care.

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**APPENDIX A. RESEARCH ETHICS MATERIALS**



**Sample Recruitment Email**

To:

Subject: Request to Participate as a Key Informant Interview for Master’s Thesis

Dear [insert name]

I would like to invite you to participate as a key informant in a 20 to 45 minute interview for a thesis project at McMaster University. My name is Katherine Liston, and I am an MSc. student in the Global Health program at McMaster University.

The purpose of the interview is to gather insight about mental health service providers’ experiences with cultural competence education and training programs. I understand that your experience in [role as] would provide a valuable perspective that could help to inform my understanding of how health care providers are taught about the role of culture in clinical encounters, and how they implement these ideas in their practice.

If you are willing to participate, please suggest some possible dates and times when an interview could be scheduled. I have attached a letter of information and consent about the project. Please review these and feel free to contact me by email at listonks@mcmaster.ca or by phone at 613-327-0009 if you have any questions or would like to discuss further.

Many thanks in advance for considering this request.

Best,

Katherine Liston

**Sample Telephone Correspondence**

**Introduction**:

Hello. My name is Katherine Liston. I am conducting interviews about mental health care providers’ experiences with guidelines on cultural competency. I’m conducting this as part of research for my Masters thesis for McMaster University’s Global Health program. I’m working under the direction Dr. Bruce Newbold of McMaster’s School of Geography and Earth Sciences.

**Study procedures**:

I’m inviting you to do a one-on-one interview that will take about 30 to 45 minutes. I will ask you questions about how mental health service providers use concepts of cultural competency in their practice. I understand that your experience in [role as] would provide a valuable perspective that could help me to understand how health care providers experience and implement these ideas.

With your consent, I will take handwritten notes to record your answers as well as use an audio recorder to make sure I don’t miss what you say. We can set up a time and place that works for us both.

I will keep the information you tell me during the interview anonymous. You do not need to answer questions that make you feel uncomfortable or that you do not want to answer.

Would you be interested in participating in this research project?

***If Yes:***

When is it convenient for you to meet?

* Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I have your email address? The purpose of this is to send you a copy of the Consent form that you can review before the interview. I will bring another copy of the form to the interview for us both to sign before the interview begins.

Do you have any questions or would like any additional details? *[Answer questions.]*

If you have any questions about this study or would like more information you can call me at 613-327-0009 or email me at listonks@mcmaster.ca. I look forward to talking to you more about your experiences at *[insert set date and time].* Thank you for participating.

***If No***:

Thank you for your time and consideration.

**LETTER OF INFORMATION / CONSENT**

**Study Title:**

**Thesis Project: Exploring mental health care providers’**

**experiences with cultural competence**

**Thesis Supervisor:**  **Student Investigator:**

Dr. Bruce Newbold Katherine Liston

School of Geography and Earth Sciences Department of Global Health

McMaster University McMaster University

Hamilton, Ontario, Canada Hamilton, Ontario, Canada

(905) 525-9140  613-327-0009

newbold@mcmaster.ca listonks@mcmaster.ca

**Purpose of the Study**

I am completing this research for a thesis project as a graduate student in the MSc. Global Health program. This thesis explores mental health care providers’ experiences with cultural competence training, and the strategies they use to provide culturally competent care to immigrant patients.

Health care providers are adapting to the diversification of the Canadian population. In order to ensure the provision of culturally appropriate care, educational programs and training workshops often include modules or learning objectives that focus on the relevance of culture in clinical practice. This research aims to contribute to an understanding of what mental health care providers in Hamilton have been taught about cultural competence, and how they feel this training has affected their practice.

You are invited to take part in this study on mental health care providers’ attitudes towards and experiences with cultural competency. I would like to conduct 20-45 minute interviews with mental health care providers in Hamilton in order to gain an understanding of this subject. I am hoping to learn about if and how you have implemented concepts of cultural competency in your practice. I also hope to find out about what you were taught about culture in school, and whether you feel this has been relevant in your work.

**Procedures involved in the Research**

If you agree to participate in the research, I will conduct a 20-45 minute long interview at a time and place that is convenient for you. I will be asking you questions about your experiences treating patients from different cultural backgrounds, and about your experiences with training programs that promote cultural competence. I will begin by asking you a few questions about your own cultural and professional background. We will then discuss how cultural competency is taught in schools, and whether this is relevant in your work. Finally, I’ll ask about your assessment of training programs. For example, I might ask if you have ever attended a continuing education session on cultural competence, and whether or not this training has been useful when you see patients who are recent immigrants. With your permission, I will audio-record the interview and take handwritten notes.

**Potential Harms, Risks or Discomforts:**

Potential harms include inconvenience of participation and temporary emotional reactions to questions that may bring to light participants’ lack of knowledge on the subject. A more severe risk could be psychological harm from perceived poor performance triggered by interview questions. A breach of confidentiality could also pose a risk should this breach cause a loss of the provider’s professional reputation.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. You can also withdraw (stop taking part) at any time. I describe below the steps I am taking to protect your privacy.

**Potential Benefits**

Although the research will not benefit you directly, I hope to learn more about providers’ experiences of cultural competency, and about how the implementation of guidelines on cultural competency has played out in reality. I hope that what is learned as a result of this study will help us to better respond to the needs of both providers and patients in an increasingly diverse environment. By identifying both the aspects of cultural competency that have been successfully implemented and that have not been put into practice, this research could help policymakers improve or expand the implementation of these guidelines accordingly.

**Confidentiality**

Every effort will be made to protect (guarantee) your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. However, since your professional community is small, others may be able to identify you on the basis of references you make. Please keep this in mind in deciding what to tell me.

The transcripts of our interviews will be kept on a computer that is protected by a password. Once the study has been completed, the data will be destroyed.

**Participation and Withdrawal**

Your participation in this study is voluntary. If you decide to be part of the study, you can decide to withdraw at any time, even after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. You have the option of removing your data from the study after the interview has taken place. If you do not want to answer some of the questions, you do not have to, but you can still be in the study.

**Information about the Study Results**

I expect to have this study completed by approximately April, 2015. If you would like a brief summary of the results, please let me know how you would like it sent to you.

**Questions about the Study**

If you have questions or need more information about the study itself, please contact me at:

Katherine Liston

613-327-0009

listonks@mcmaster.ca

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HIREB at 905.521.2100 x 42013.

**CONSENT**

I have read the information presented in the information letter about a study being conducted by Katherine Liston of McMaster University.

I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

I understand that if I agree to participate in this study, I may withdraw from the study at any time. I have been given a copy of this form. I agree to participate in the study.

*I agree that the interview can be audio/video recorded. Yes No*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Participant (Printed) Signature Date

Consent form explained in person by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Role (Printed) Signature Date

**FOLLOW-UP**

*I would like to receive a summary of the study’s results. Yes No*

*If yes, where would you like the results sent:*

*Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**APPENDIX B. DATA COLLECTION MATERIALS**

Semi-Structured Interview Guide for Mental Health Service Providers

Introduction

I would like to thank you again for your willingness to participate and to remind you to let me know if there are any questions that you would prefer not to answer, or any answers that you are uncomfortable with and would like to have removed from the record.

The purpose of this research is to understand mental health service providers’ experiences with cultural competency.

Are you comfortable to proceed?

1. **Context and Background Questions**

Before we get started, could you just remind me,

* 1. How long have you been practicing?
	2. Can you describe the kind of work you do?
		1. Can you give me a better idea of the kinds of mental health disorders you deal with?
		2. What is your educational background?
	3. Can you describe your patient base?
		1. How old are most of your patients?
		2. Where do most of your patients come from?
1. **Multicultural Education**
	1. When you were in school for [field of work], did you learn about cultural issues relevant to your work?
		1. What courses dealt with culture?
		2. Were these courses compulsory or were they electives?
		3. Do you remember what kind of cultural issues you learned about?
		4. Can you think of a time when this has been helpful to your work?
	2. Since you finished school, have you attended any workshops or trainings related to cultural diversity?
		1. Can you tell me about the training?
			1. Was it optional or mandatory?
			2. Who ran the training?
			3. Was the training specifically related to mental health?
		2. Can you think of a time when the training has been useful?
		3. How would you improve the training to be more relevant to your practice?
2. **Cultural competence in practice**
	1. Do you find it relevant to consider culture when you are interacting with patients?
		1. Can you give an example of a time when you feel you provided care that was culturally competent?
		2. Is there a time when you could have done more to provide care that was culturally competent?
		3. Can you think of a time when a patient’s cultural beliefs interfered with your ability to provide care for them?
	2. Does your office do anything in particular to help make sure that people from all cultural backgrounds are comfortable?
	3. Do you have any patients who don’t speak enough English to communicate effectively in English? [What do you do then?]
		1. Can you describe what it’s like to have [an interpreter/a family member/a friend] translating?
	4. Is the term “cultural competence” familiar to you?
		1. In what kind of context have you heard about it?
3. **Improvements and recommendations**
	1. Overall, do you think [insert profession] are able to provide the same level of care to migrant and Canadian-born patients?
	2. [If relevant:] What do you think can be done to help [insert profession] to provide culturally competent care?

Thank you for your candid responses. Are there any other issues you think are important to discuss regarding the provision of culturally competent care for immigrant patients?