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Staff competence in dealing with traditional approaches

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Abstract

Health care and health care systems should be seen and understood in their socio-cultural context. Modern urbanized societies are likely to exhibit health care pluralism, and different therapeutic approaches are available side-by-side. The various models may take their origin in different cultural traditions, but in most societies one type of care is at a given time considered "above" the others. However health care activities in all societies show a degree of interrelation, reflecting societal changes in which normative practices, value systems and structures change over time. In the current Western health systems evidence-based biomedical care is the prevailing system taught to all professionals.

The present paper outlines the prevailing health paradigms, and the advantages and shortcomings of the various approaches and their relation to modern care will be discussed. With increased multicultural backgrounds of patients there is a need for mental health professionals to recognize the existence of traditional approaches and be aware of the parallel systems of care. Competent treatment of such patients requires that mental health professionals are aware of this and exhibit a willingness and ability to bridge between the more traditional and the Western approaches to treatment. The delineations and various aspects of the concept cultural competence and its dimensions will be discussed from a clinical perspective.

Comparative studies of the various Western and the traditional approaches respectively will be reviewed.

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1. Introduction

With increasing globalization mental health professionals working in Western countries are likely to be confronted with the consequences thereof as reflected, for example, in the multicultural patient population. A considerable proportion of these patients may have chosen alternative approaches of treatment or indigenous healers, either prior to or concurrent with the current contact with health services. This is so, partly because their belief systems and explanatory models may coincide better with this approach to treatment, and partly because they may have experienced limited access to health services in their country of origin. Today, the majority of mental health professionals working in urban settings will encounter such patients in their daily clinical life.

If the complex treatment needs of these patients are to be fulfilled, it is of importance that staff working in mental health settings possess adequate competencies to deal with this diversity. Knowledge about different approaches to health care, their advantages and disadvantages, respectively, is a necessary part of cultural competence in order to understand the motivations, help-seeking behaviour and choice of treatment of patients of other ethnic backgrounds. In light of the above, the present paper will analyze such approaches as well as findings from studies comparing different approaches – all seen in the perspective of cultural competence. Possibilities for interactions between indigenous healers and professionals will be discussed as well as training perspectives of the latter group.

2. Definitions of cultural competence

What constitutes cultural competence is up for debate, and Kleinman and Benson [28] state that it has become a fashionable term for clinicians and researchers, however, it has yet to be defined sufficiently well to be operationalized for clinical training. The prevailing definitions may reflect different approaches to the concept, thus cultural competence may be delineated in several ways [38].

According to Wikipedia [41] cultural competence is a term used for the ability of people of one culture to understand,

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communicate, operate, and provide effective services to people of another given culture.

The term is fairly recent but has become widely used in the fields of health care as well as education and social work and used to discuss acceptance of persons from a wide array of diverse backgrounds and cultures. Cultural competence implies that the professional exhibits behaviour which avoids racist or discriminatory practices and provides care to people of different cultural backgrounds, that is sensitive to linguistic, religious, and class differences.

In the clinical based definition cultural competence is defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross – cultural situations [6].

Considering it from a need based definition cultural competence is the acceptance and attention to the dynamics of difference, the ongoing development of cultural knowledge and the resources and flexibility within service models to meet the needs of minority populations [6].

Defined from a market perspective, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, techniques and marketing programs that match the individual's culture and increase the quality and appropriateness of health care and outcomes and that lower costs [7].

Cultural competence is not a static phenomenon but a developmental process moving along a continuum. The spectrum includes: (i) cultural destructiveness; (ii) cultural incapacity; (iii) cultural blindness; (iv) cultural pre-competence; (v) cultural competence; (vi) cultural proficiency [6]. If a health care system wants to increase its cultural competence, it needs to value diversity, be able to assess itself culturally, be aware of how cultures interact, incorporate and institutionalize cultural knowledge, and adjust service delivery in order to understand and be aware of diversity between and within cultures. Health systems should make an effort to assess where they fall along the continuum [6].

Some believe that cultural awareness and cultural sensitivity are steps along the road to cultural competence. Whereas the topics have similarities and overlap, however, cultural competency emphasizes the idea of effectively operating in different cultural contexts that is not included in "awareness" or "sensitivity" Cultural competency thus goes beyond awareness or sensitivity [23].

3. Values and missions

Most Western health institutions today have missions that are available to all; staff as well as patients and their relatives, and that reflect the value system of the organization in question. Such missions typically focus on, for example:

- respect for the individual patient;
- involving the individual in all decisions regarding his/her health;
- recognizing that patients may have different values that should be addressed;
- value systems are dynamic and highly influenced by the surrounding culture.

Consequently, in several countries there are clear policies to increase the quota of certain groups, e.g. ethnic minorities among the medical students, but little effort to analyze the effects of an altered composition of students on the value systems and cultural ambience of the medical schools and subsequently of the health care systems [12].

The question remains to what degree Western health care systems have adjusted to the present patient population with its increasing proportion of ethnic minorities. Nielsen [32] points to the fact that with respect to health services there has been a focus on how to "integrate" persons with different disabilities to ensure an equal access to services for such groups but that a similar focus on integrating ethnic minorities by recognizing and adjusting to their needs lags behind. In relation to health services there may be different ways to go: (i) the approach that ethnic minorities need to adjust to the available system; (ii) the approach that the health system should adjust to the need of the population it is supposed to serve; or (iii) the approach of mutuality that both parts try to adjust to each other [7]. Scrutinizing the hospital system and the culture surrounding it, it seems in many ways very limited to what extent the system has adjusted its routines and procedures, including providing information in different languages, in order to fulfil any special needs of various ethnic groups utilizing it. Lack of language abilities or lack of knowledge about the structure of services may result in a patient not receiving adequate care or treatment or premature termination [32]. As a result the condition may worsen and the outcome become less favourable.

One may say that our health system adheres to a culture that we as professionals implicitly take for the "ideal" culture, and we may tend to use its values as a measurement stick when evaluating other systems. When encountering patients coming to us for help, but representing very different value systems, we may, as professionals, exert a certain pressure on such patients by signaling that the values they represent are not "comme il faut", or we may try to convince them that the values our health services maintain are the correct ones.

The question is to what extent such influences take place in the daily clinical work with migrant patients? We may further ask whether it is at all acceptable to exert such influence given that our values may run counter to values in the other culture? According to Gullestrup [15] discussions about such issues are all too rare in our public systems.

Thus, it is not surprising that there are few if any systematic investigations of the changes seen in attitudes and values of health care systems in the light of the changed population of students and other professionals. Teachers of medical students generally do not consider issues such as cultural competence when trying to improve their own understanding of the students or the educational setting in which this training takes place [12].

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