Multicultural Research and Practice: Theoretical Issues and Maximizing Cultural Exchange

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This article reviews literature on cross-cultural approaches to assessment, research, and clinical practice, culminating in recommendations for using a “cultural exchange” approach when working with multicultural clients. It examines challenges in studying culture and mental illness, including methodological issues and problems in defining constructs in multicultural research. Measurement of disorders cross-culturally, including efforts to validate depression measures for use with multicultural populations, is also discussed. Perspectives on cultural competence are presented, including the American Psychological Association Multicultural Guidelines, and a “cultural exchange” approach to therapy is presented as a tool for maximizing the benefit of therapy with multicultural clients. Three clinical vignettes are presented to illustrate the use of this approach and how identifying the commission of Type I and Type II multicultural errors can enhance clinical work.

Keywords: culture, cross-cultural, therapy, depression, assessment, case study

This article aims to provide a comprehensive framework for clinicians and researchers working with multicultural clients. This will be done by reviewing theory regarding the interaction of culture with assessment, diagnosis, and treatment of depression. Depression is used as an exemplar mental disorder because of being common across cultures and widely researched; however, most of the recommendations are applicable to other psychological disorders. The article will examine current views on multicultural competence, including the American Psychological Association (APA) Multicultural Guidelines, which can be used to inform a multicultural stance toward all therapy interactions, followed by a discussion of issues related to cross-cultural validation of depression measures. It will be shown that defining culture and cultural interaction is a complex and ever-changing phenomenon. Furthermore, efforts to truly address culture and mental illness are only just beginning to be realized. Methods of measuring and treating disorders are evolving as traditional views are being challenged and improved upon. Finally, clinical case vignettes are presented to illustrate the use of a “cultural exchange” approach to therapy with diverse clients. The aim is to illustrate the complexities of multicultural counseling and how addressing such complexities can lead to superior clinical work with all clients.

Studying Culture and Mental Illness

The earliest endeavors to create cross-cultural understanding of mental illness are credited to Kleinman (1977), who argued that cultural variations in mood disorders do exist based on a particular culture’s shaping of normal and deviant behavior. He emphasized the need to examine the social implications of illness. Professionals were encouraged to respect indigenous classifications and conceptualizations for disorders. Further emphasis was placed on understanding the limitations of current diagnostic categories, especially in a cross-cultural setting. Views on the relationship between depression and culture fall into two general camps. The universal view argues that depression is similar across cultures and thus can be accounted for by one unitary quantitative measure, whereas the social constructionist view asserts that depression is culture-bound and measures cannot be generalized across cultures (Redmond, Rooney, & Bishop, 2006; Draguns & Tanaka-Matsumi, 2003). These views have significant implications related to how depression is studied across cultures. Currently, the World Health Organization (WHO) studies depression as part of larger epidemiological research on disease and illness. The 1996 publication of The World Health Report found depression to be among the top disorders to cause disability worldwide (fifth for women, seventh for men; Desjarlais et al., 1996, cited in López & Guarnaccia, 2000). An important finding of the study was the relationship between mental illness and culture. Factors such as hunger, work conditions, and domestic violence were related to levels of depression in women. The authors thus argue that depression is as much a social illness as it is a mental illness. It seems that even a universalist view that a disorder has commonalities across cultures will need to account for socially constructed variations in perceptions of the disorder, pathways to treatment, attitudes toward mental health care, and social factors that create/sustain the disorder.

Methodological Issues in Cross-Cultural Research

One of the earliest large-scale studies of cultural differences in mental illness was the United States–United Kingdom (US-UK) Diagnostic Project (Cooper et al., 1972, cited in Draguns &
Tanaka-Matsumi, 2003). This study found that a larger percentage of patients in New York were diagnosed with schizophrenia, whereas patients in London were more likely to be diagnosed with depression. The study found that differences disappeared when using standardized diagnostic criteria (International Classification of Diseases, Eighth Revision [ICD-8]). An important finding from this study was that clinicians were likely to contribute to cultural differences, not just patients, although the results suggest that use of standardized diagnostic criteria can alleviate such bias. One limitation of the study is the fact that British and U.S. cultures share significant overlap.

Research on the cultural influences on mental illness has been marred by methodological issues (Redmond et al., 2006). Although the US-UK project indicated that validity was improved with the use of standardized diagnostic criteria, Canino, Lewis-Fernandez, and Bravo (1997) state that such criteria drown out cultural nuances and prevent the formation of relevant hypotheses important to culture. They also argue that the criteria are problematic because they are bound in Euro-American ethnocentrism. One difficulty in accurate assessment of psychopathology in cross-cultural situations involves social distance and empathy. That is, the more unfamiliar a person’s culture, the more difficult it is for one to experience it empathically (Draguns & Tanaka-Matsumi, 2003). Indeed, psychologists’ tendency to group and categorize people may prevent them from acknowledging the substantial overlap among various cultures. This leads to pathologizing cultural variation in mental disorders.

Another struggle with studying mental illness cross-culturally is difficulty finding common terminology. Some cultures do not have a dictionary-equivalent word for depression, and most cultures vary in terms of the connotative meaning of the word (Tanaka-Matsumi, & Marsella, 1976). Using U.S. criteria and definition, there is broader cross-cultural support for a similar phenomenon that one might call depression. The study by Weissman et al. (1996) was one of the first major attempts at multicultural comparison of mood disorders. They found little variation in bipolar mood disorder, which is not surprising because of the disorder’s strong biological etiology. However, they found that sleep difficulties and loss of appetite were consistent depressive symptoms with the use of standardized diagnostic criteria, Canino, Lewis-Fernandez, and Bravo (1997) state that such criteria drown out cultural nuances and prevent the formation of relevant hypotheses important to culture. They also argue that the criteria are problematic because they are bound in Euro-American ethnocentrism. One difficulty in accurate assessment of psychopathology in cross-cultural situations involves social distance and empathy. That is, the more unfamiliar a person’s culture, the more difficult it is for one to experience it empathically (Draguns & Tanaka-Matsumi, 2003). Indeed, psychologists’ tendency to group and categorize people may prevent them from acknowledging the substantial overlap among various cultures. This evidence of course suggests that there is more variation in mental disorders.

Chang et al. (2008) examined the validity of using Diagnostic and Statistical Manual (DSM) diagnostic criteria with a Korean population. They found that Koreans met diagnostic criteria for depression about one-fourth as often as people in the United States, suggesting that the diagnostic threshold may differ despite the actual specific criteria being valid with a Korean population. However, there were some variations. Koreans showed four times the amount of work-related impairment than those in the United States. The type of symptoms to first appear differed across cultures as well. Depressed mood was first noticed among those in the United States (when the course of the disorder was less severe) with psychomotor retardation or agitation and feelings of worthlessness and guilt occurring when depression was more severe. In Koreans, concentration difficulty and low energy symptoms appeared earlier, while psychomotor retardation or agitation and feelings of worthlessness and guilt appeared when depression was more severe. Of important note is that depressed mood is often a required symptom for a DSM diagnosis of depression (that or anhedonia). Thus, the cultural differences in the endorsement of depressed mood may be a factor in the observed prevalence differences.

Measuring Mental Illness Cross-Culturally

There is empirical evidence suggesting that universal depression scales can be used to measure depression across cultures (Arrindell, Steptoe, & Wardle, 2003). However, other research cautions that such measures may still miss important cultural nuances and can never avoid ethnocentric interpretation by the assessor (Redmond et al., 2006). Draguns and Tanaka-Matsumi (2003) examined a large body of research pertaining to studying depression across cultures. Several important conclusions were found to guide cross-cultural measurement. First, the authors note that the increase in efforts to standardize measures for cross-cultural use have allowed researchers to test hypotheses about the variation of psychopathology across cultures. The authors state that “cultural research on psychopathology starts with the development of scales and other instruments of assessment. It culminates with their application across and within cultures” (p. 770). Thus, cross-cultural validation is considered to be an integral part of a scale’s validation process. The authors also found that cultural variability was more pronounced when psychopathology was mild, and cultural difference dissipated as pathology became greater. Symptom clusters such as guilt and somatization had the greatest variability across cultures. Finally, a major issue noted in the extant research is that culture of the clinician (researcher, assessor, etc.) was often left out, overlooked, or deemed as unimportant. This further highlights the ethnocentric bias persistent in cultural research. The majority of research on culture thus focuses on the participant’s or client’s cultural factors, which is incomplete. True cultural research must look at the discrepancy between the observer (researcher, clinician, etc.) and the participant or client. Failure to do so increases the likelihood to pathologize those that are culturally different and understates the effects of cultural disparity on assessment and diagnosis.

Hofstede’s (Draguns and Tanaka-Matsumi (1980, 1991, 1980, 2001, 1991, 2001) cultural measure is one of the more widely used scales to quantify and describe culture in cross-cultural studies. It measures five dimensions of culture (Power Distance; Uncertainty Avoidance; Individualism/Collectivism; Masculinity/Femininity; and Confucian Dynamism, cited in Redmond et al., 2006). A variety of research has examined variability of depression and culture using Hofstede’s scale (Arrindell et al., 1997; Diener, Diener, & Diener, 1995). However, the scale has been criticized as being redundant, overly narrow, and used inappropriately beyond the scope it was originally intended for (Redmond et al., 2006). Some researchers have critiqued the methodology used to extract the factors (Bond, 2001), while others have failed to replicate Hofstede’s factor structure and suggest that the factors are suspect (Spector, Cooper, & Sparks, 2001). While the scale may have continued use in cross-cultural research, the data suggest that the scale should be used cautiously. At best, Hofstede’s factors appear to be incomplete or too narrow to examine many cultural nuances in socially mediated facets of depression and psychopathology.
Validating Instruments for Multicultural Use

There are a large number of studies that aim to ascertain cross-cultural support for a variety of depression measures, including the Depression in the Medically Ill Measure of State Depression (DMI-10) (Chan, Parker, Tully, & Eisenbruch, 2007), the Beck Depression Inventory II (BDI-II) and the Center for Epidemiologic Studies Depression Scale (CES-D; Kojima et al., 2002), and the Hamilton Rating Scale for Depression (HRSD; Fava, Kellner, Munari, & Pavan, 1982). Many of these studies focus on the examination of exploratory factor analysis (EFA) factor structure, test-retest reliability, and internal consistency reliability of scales translated from English to another language for use with the latter’s native population. While consistency is an important facet of the psychometrics of these translated scales, reliability is necessary but not sufficient to establish validity.

While many cross-cultural validations of depression inventories have merely reported internal consistency reliability and EFA results, researchers are beginning to believe that such methods are not sufficient and arguing for use of confirmatory factor analysis (CFA) to test specific hypotheses about the scale structure (Furukawa et al., 2005). CFA is a form of scale analysis using structural equation modeling to verify theoretical models purported to be measured by a scale. Models show relationships among observations (i.e., scale item scores) and latent variables (i.e., a construct, such as depression, thought to “load” onto the score of the observation). Information about variances, covariances, and model fit are used to examine the hypothesized factor structure of the scale. Use of CFA allows for the examination at the scale (or item) level and allows the researcher to examine the behavior of the factors predicted to be underlying the scale items. Although EFA is more widely used in psychometric research, the method is often erroneously extended beyond its intended use.

Perspectives on Cross-Cultural Competence

Definitions and perspectives of what it means to possess cultural competence vary. Sue (1998) describes cultural competence as the possession of the knowledge and skills of a particular culture to an extent that allows the delivery of effective services to such a population. Other theories point at the ability to move between two cultural perspectives or, more broadly, the ability to recognize the importance of culture and incorporating culture into assessment and treatment delivery (see Whaley & Davis, 2007). Sue and Torino (2005) more recently described cultural competence as follows:

Cultural competence is the ability to engage in actions or create conditions that maximize the optimal development of the client and client systems. Multicultural counseling competence is achieved by the counselor’s acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds) and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (p. 8)

This perspective on cultural competence includes the acquisition of cultural knowledge, as well as a general approach to thinking about, studying, teaching, and developing policy and practice to reflect such thinking.

Whaley and Davis (2007) reviewed the literature related to the increasing need for multicultural competence among clinicians. They cite research to argue that there is an increased need for cultural competency due to the increasing cultural diversity of the U.S. population. In addition, they note issues related to underutilization and overutilization of mental health services. Underutilization refers to ethnic minority groups using dramatically fewer mental health services than Caucasians, which the authors describe as a case of unmet needs. Overutilization refers to ethnic minorities being given diagnoses of more severe disorders or being in greater distress. Other arguments made in the review state that cultural competence research addresses needs put forth by the APA and the American Counseling Association (ACA) code of ethics. Furthermore, issues of external validity are common with regard to generalizing scientific findings to other cultures. Thus, research on cultural competence is called for on grounds of empirical rigor as well. Finally, the authors argue that cultural competence is an essential component of evidence-based therapy. Traditionally, evidence-based therapy research has failed to extend to ethnic minority groups, and the authors see cultural competence as requisite evidence criteria for such therapies.

The APA’s six Multicultural Guidelines assert that cultural competence involves more than cultural knowledge (APA, 2003). While the first guideline emphasizes the importance of knowledge of differences, the second guideline states “psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves” (p. 382). The notion of the psychologist as “cultural being” highlights an important, and often overlooked, aspect of cross-cultural work in research and clinical practice. In addition to having an acute lens to assess the cultural world, a psychologist must be aware of the lens itself and its tendency to focus and bend images based on his or her own cultural beliefs and values.

Not only is knowledge of cultures insufficient to work with culturally diverse clients, but developing a complex understanding of every culture is challenging, if not impossible. It is unlikely that a clinician will possess a high level of expertise on more than a few cultural groups. Chu (2007) proposes the use of a cultural “approach” as a means for working with various cultural groups. The model is essentially a general therapy framework that includes a deliberate effort to “maximize the cultural exchange” (p. 39). The author describes this exchange as ongoing attempts to challenge assumptions and test cultural hypotheses. That is, there is a continual dialogue between the client and clinician regarding culture, cultural assumptions, and cultural interactions in therapy. Thus cultural interaction is not an examination only of the client’s cultural background, but instead focuses on the discrepancy between the clinician’s culture and the client’s, a sentiment that is illustrated in the following vignette.

Maximizing Cultural Exchange: The Case of G

G. is a 54-year-old Bosnian refugee who came to the United States with his adult daughter to escape the war and strife in Bosnia, to which he had lost his wife and many other friends and
family members. G. came to therapy because of “suddenly waking up” in the nighttime with feelings that something was wrong. G. spoke almost no English despite living in the United States for 10 years, and all therapy was conducted through an interpreter that would be present in the room for each session. Initial attempts to understand G.’s symptoms were fruitless, only leading to general descriptions of sudden waking and possibly some feelings of anxiety. It seemed that G. was experiencing posttraumatic stress disorder (PTSD) related to the war in his home country and the tragic losses he experienced. However, using a typical treatment approach for working with trauma seemed impossible. There was virtually no therapeutic alliance, and G. appeared to be frustrated at attempts by the therapist to talk about his symptoms. Rather than fruitlessly press for more information, the therapist asked G. whether there were psychologists in Bosnia. G. described himself as a traditional man, stating that the concept of coming to a therapist usually meant that one was “crazy.” He was concerned that he would be perceived as crazy by the therapist. He was told what PTSD was, and how a therapist in the United States would view this as an anxiety disorder in reaction to experiencing tragedies like he had. The therapist reassured him that he was not crazy and that the symptoms could be treated by talking about them. He asked G. how he felt talking via an interpreter, and while G. expressed understanding of the necessity of it, he admitted that it made him feel inadequate that he could not communicate more directly. G. shared that he has not spoken more than a few words to anyone other than his daughter since he arrived in the United States. This was because of feeling uncomfortable learning a new language, yet it led to problems because his daughter was living her adult life in the United States and did not have time to be there for him always. He expressed a desire for social interactions, but at this point felt foolish trying to initiate communication with others. Through the course of therapy, G. described a desire to have friends to play chess with, a game he felt he was very good at. They explored ways that G. could develop friendships by finding a small group of Bosnian immigrants through an organization the interpreter knew of. G. developed some friendships and was able to learn more English over chess games with a friend at a local coffee shop. His new friend had also lost loved ones in the war, and they relied on each other as a source of support. At termination of therapy, G. reported that he was sleeping soundly, with no sudden awakenings.

In this case, addressing the cultural dynamics in the session became more important than initiating a treatment plan. Never during therapy did G. talk in detail about his trauma, work on relaxation techniques, identify triggers, or take medication. The cultural exchange in session helped G. get what he wanted most, which was social support where he was able to address his PTSD symptoms through channels that felt more natural to him than therapy. Clinicians must be aware that addressing the cultural exchange is not an addition to therapy, but rather a therapeutic intervention on its own.

Chu (2007) argues that this cultural exchange approach can help a clinician watch for what the author calls Type I and Type II cultural errors. Analogous to hypothesis testing errors, the Type I cultural error is the assumption that a clinical issue is cultural when it is not. For example, a client who consistently arrives late for therapy sessions may be viewed as doing so because of cultural attitudes toward time or punctuality. In actuality, this may be an important clinical issue that is unrelated to culture. The Type II cultural error assumes an issue is not cultural when it is, such as labeling a client who is acting out cultural beliefs concerning respect toward authority figures as being passive and deferential (Chu, 2007).

Type I Cultural Error: The Case of D

D. was a 20-year-old female Chinese international student who had only been in the United States for a few weeks. She sought therapy to address difficulties adjusting to U.S. culture, reduce anxiety about choosing a major, and to have a safe place to ask questions about university life. While her English was fluent, it was limited enough that it still led to difficulties in expressing some ideas, especially those related to feelings. Using a cultural exchange approach, the therapist attempted to ask D. about how she perceived talking about emotions in session. He assumed that D. had a cultural value that led her to be less emotionally expressive, and he wanted to start a discussion about this to avoid making culturally biased assumptions. When asked about how her culture viewed emotions, D. expressed confusion about the question, and the therapist attributed this to both the language barrier and the notion that individuals from Asian cultures are less inclined than Americans to express emotions openly with a stranger. Therapy took on a problem-solving approach, with the therapist directing D. to make use of international student resources on campus and attempting to make friends as a means to practice her English. D. often talked about classes and her desire to join professional clubs. The therapist viewed her as a hardworking student who did not seem interested in her personal life. Five weeks into therapy, D.’s interactions with American students had increased and her English was noticeably better. The therapist pointed out that they were able to converse more directly. He again asked D. about expression of emotions in her culture. She explained that she believed many Chinese people did not share emotions, except with close relatives or friends. However, she stated that she was not typical of her culture, because she considers herself more emotional and enjoys talking about her feelings, something she had been enjoying with her new American friends. It turned out that D. simply did not know the English version for some of the words being used in therapy, such as assertive and rejection. After teaching her some of the words, the therapist was able to learn that D. desperately wanted to have friends at school, but was unsure about how to initiate conversations with others. In addition, D. was having difficulty with her roommate but was afraid of being offensive by raising her concerns to her roommate. From here they were able to work on assertive communication skills and to role-play initiating social conversations. The therapeutic alliance also became stronger as D. delighted in sharing stories about her hometown in China. She also expressed a desire to come to the United States because she did not feel her values fit well with some common Chinese values.

This case shows how the assumptions a therapist makes about other cultures may blind him or her to the heterogeneity within cultures. The therapist had assumed from her lack of responding that D. did not consider it appropriate to discuss emotions, when in fact it had been a misunderstanding based on the language barrier. While a cultural exchange approach serves to enhance understanding of dynamics for both the therapist and client, it can be easy to
overassume the impact of culture. The culturally competent therapist is aware of within group variability as well as shared variance across cultures.

Type II Cultural Error: The Case of R

R. was a 30-year-old Columbian male who had lived in the United States for 5 years. He was seeking therapy for symptoms of depression related to insecurities in his relationship with his girlfriend. R. stated that he would become anxious about his physical appearance, including his weight and acne, and was afraid that his girlfriend would decide that he was not good enough for her and leave him. He interpreted benign behaviors, such as her desire to go to the mall with her mother, as her rejection of him. R. also reported fears of abandonment early in life back in Columbia, recalling throwing temper tantrums when his mother would leave the house to go to the store. During therapy sessions, R. would often focus on recent events where he felt insecure and wished his girlfriend would behave differently to reduce his anxieties. The therapist made many attempts to help R. examine how his insecurities may stem from early childhood events he seemed unwilling to explore. Because the therapist was unfamiliar with Columbian culture, he asked R. about his values about disclosing personal information in therapy. R. shared that his culture valued “machismo” in men, referring to acting in an assertive or even aggressive manner, being unemotional, providing for his family, and other traits that one might equate with a traditional masculine gender role. R. expressed a reluctance to talk about his past, because this was an emotional topic, and he did not want to express vulnerable emotions in front of a male therapist out of fear that he would be humiliated and demasculinized. The therapist informed R. that this is similar to what happens in the United States, where men struggle to be emotionally open based on gender role expectations. R. rejected the notion that these were similar, because he did not feel the pressure was as great for American men. In fact, he even expressed a desire to date American women out of a belief that they would not require him to adhere to such a strict masculine code. R.’s attendance at therapy following this session was sporadic and superficial. The therapist suggested that R. was resistant to the therapy process because it involved talking about emotional material. R. often agreed with this notion but did not engage in therapy further. R. suggested they terminate therapy, and during the termination session the therapist admitted that he had made an error in assuming that R.’s experiences were similar to what American men experience. R. stated that he felt belittled and misunderstood, like his identity as a man was being challenged at the expense of understanding his background. At this discovery the therapist and R. engaged in sharing how gender roles were viewed in Columbian and U.S. culture. R. enthusiastically described the cultural norms in his family. R. later shared how being able to talk about his culture to a naïve therapist made him feel intelligent and worthwhile in a therapy relationship that initially made him feel weak and stupid. It was through this discussion that R. revealed that early in life his father had left him and his mother for another woman. R. believed that his father no longer desired to be a family man who provided for his wife and child, and instead sought out relationships with younger women. The feelings of abandonment were intimately tied to confusion about his own role as a man, one he continued to struggle with in his adult life.

Only through a cultural exchange was the therapist able to establish a therapeutic relationship with the client. Without previous knowledge of machismo, one may simply interpret that the client is defensive. Through the cultural exchange, the therapist enabled the client to feel competent and capable, allowing him to engage in the work of therapy. These exchanges also increase the cultural competence of the therapist for identifying similar issues in future clients. Working with every therapy client using a cultural exchange approach can improve the therapy relationship and open doors of exploration for the therapist and client.

Conclusions

This article reviewed current thinking and research regarding cultural interactions with mental illness. It was argued that definitions of culture are variable and research findings from the WHO and other cross-cultural studies warrant careful examination of the interaction between mental illness and culture. Although studies suggest that a phenomenon called depression likely exists to some similar extent across cultures, caution must be used in understanding cultural nuances. Research on cross-validation of depression measures was examined, and current findings suggest that many translated measures of depression show promise; however, the methods used to establish cross-cultural validity are inadequate. It was also argued that the increased use of CFA is warranted to test specific hypotheses regarding a scale’s behavior in other cultural settings or with diverse clients.

Of utmost importance is examination of culture as an exchange between two people in a clinical setting, rather than merely looking at a particular client’s cultural beliefs and values. Case vignettes were presented to illustrate some of the complexities of the cultural exchange approach. It was argued that competence extends beyond cultural sensitivity or knowledge and includes a comprehensive approach to clinical work, research, teaching, and policy-making.

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