

The virtues of feeling culturally incompetent*

LESLIE SWARTZ

Department of Psychology
Stellenbosch University, South Africa

ABSTRACT

In a diverse and complex world, the notion of 'cultural competence' is offered by some as an ethical solution to health care work which is culturally naïve or inappropriate. Notions of cultural competence, however, may obscure the fact that many clinicians, regardless of background, may feel ill equipped to deal with difference in their daily work. Drawing largely on South African examples, I suggest that issues of cultural incompetence, linked both to personal anxieties and to the ways in which health care systems are structured, may be important to explore – personally, professionally, and politically. Through examining the difficulties of our own work and recognizing these, we may learn more only by learning a set of skills about the 'other'.

The notion of 'cultural competence' seems to be everywhere these days, and presented as a solution to the problem of providing humane and ethical health care in an increasingly diverse society.¹ Why, then, is there emerging amongst practitioners and people who write about culture and health a sense of exactly the opposite of 'cultural competence'²? Should we be worrying about this sense? How seriously should we be taking the difficulty in distinguishing between what may approvingly be called 'cultural competence' and what is disparagingly dismissed as 'political correctness'?

There may be a problem with the easy use of the notion of 'competence' itself. There is much that is enormously impressive about the cultural competence movement and with the strides taken in this regard in the USA, Canada, and Australia in particular. But the notion that it is possible to become 'culturally competent' may silence the feeling of being culturally inept, and always in the wrong place, always out of step. This feeling of ineptitude may be viewed as a fault or a flaw, a lower state of being than that of knowing what should be done culturally, but I am not sure that it is. As Kai and his colleagues have recently shown, there may well be great benefits for allowing some space in which it is possible for clinicians to acknowledge a visceral but probably somewhat shameful experience.³ Few clinicians working in unfamiliar environments can not have had nasty questions in their heads, like 'What I am doing here? Whom do I think I'm fooling? Can't they see that I don't know what I'm doing?'

* An earlier version of this article was presented at the conference, *From tolerance to respect: cultural competence in practice*, held by the Multicultural Disability Advocacy Association of NSW and the National Ethnic Disability Alliance, Sydney, September 2006.

If we are to deal honestly with these questions, it becomes necessary to talk, and think, personally, and not just about generic competency skills. In my own case, some of the discomfort and feeling of being a fraud comes from my own positioning – I am a white, able-bodied South African male academic who has chosen to work in a number of fields including culture and mental health and disability, fields which all legitimately foreground the limitations of my identity to be an expert or ‘competent’ in the fields in which I have chosen to work. The foregrounding of insider knowledge, so crucial both to the transformation of the way we see expertise in mental health care in South Africa in the post-struggle era, and also to the ‘nothing about us without us’ philosophy of the international disability rights movement, combine to make me edgy, and appropriately so, I think, about the extent to which I will ever become ‘culturally competent’ in my work.

But this is only part of the reason to feel uncomfortable about cultural competence – another side to it is that horrible sense of really not knowing what is going on, feeling like a fish out of water, feeling, as Valerie Sinason would have it, ‘stupid’ or ‘stupefied’, not just through lack of knowledge in an intellectual sense, but at the sense of a gulf of experience between myself and people I work with.⁴ Along with this sense of being stupefied is a deep guilt about feeling this way, a wish to do better, to be better, to be someone else. And here in a sense is the rub – the only way it feels that I could be doing this properly would be if I were not me, if I were someone else. My own identity takes on a subjunctive or an ‘as if’ quality – I will pretend to be doing this work properly on condition that everybody else pretends I am the right person to do it. And so, somehow, we muddle on.

It would, I think be something of a relief were it possible to attribute this overwhelming sense of cultural incompetence only to my own race, class, gender, and disability positioning. If I could simply say to myself, for example, well, if I were a black woman, this would go away. Perhaps some of it would, but then other things come into play, potentially. Watermeyer who has a severe visual impairment, has written movingly about his difficulties in separating his own issues and expectations from his group work with people with visual impairment.⁵ Christian, Mokutu and Rankoe discuss their positioning as black students at an historically white university in South Africa and conclude, amongst other things, that far from ‘solving’ the cultural problems of the service delivery arm of the training centre for clinical psychology, their work raises other questions.⁶ Black students face difficulties not faced by white students, above and beyond the implicit institutional racism which is ever-present. For example, a black woman student finds it hard to counsel a family the head of which is an older woman who, according to cultural practice, calls her ‘granddaughter’. A Sotho-speaking therapist, matched linguistically with a Sotho-speaking family, finds himself working with this family through the medium of English because he finds a lack of conceptual equivalence between the world-view of his native tongue and that of the medium within which he has been acculturated into becoming a

psychologist. The clients, similarly, feel more relaxed in seeing psychotherapy as an 'English thing'. Hester van der Walt, a white, Afrikaans-speaking nurse practitioner, describes her horror at recognizing her own internalised racism against white Afrikaners when working in a community health programme.⁷ She blames the poor, marginalized, white people with whom she works, for their health problems (in essence, blaming the victim), where she is prepared as a politically progressive South African, to have a much more contextual and less victim-blaming attitude towards poor black clients with similar health problems.

In her work on nursing in South Africa, van der Walt calls this phenomenon 'too close for comfort', and she finds this phenomenon amongst black nurses as well, with people she observes being more harsh towards members of their own communities than towards outsiders. But van der Walt talks about 'too close for comfort' and I, in my earlier remarks, have talked of my own feelings about being, in a sense, 'too far away', or 'too distant for comfort'.⁸

The core of the problem here, of course, is the notion of 'comfort' itself. There is something just too easy about the idea that we can or should be comfortable. This is not, in my understanding, what is intended in the notion of cultural competence - there is a difference between feeling empowered to do things differently and a sense of having achieved everything that needs to be achieved - in a word, with complacency. And complacency is not simply a kind of moral failing - it is not especially useful, I believe, to see complacency in these terms. Complacency of a certain type is a kind of refuge from discomfort and from feeling overwhelmed. Some years ago I was invited to a meeting hosted by the South African Human Rights Commission on language issues in health care. A group of disabled women had approached the Commission with the plea that in spite of the fact that there are 11 official languages in South Africa, as well as a policy to promote South African sign language, it is impossible to access the full range of health care in our country in every language. The meeting was held in the heyday of our new democracy, a time in which we all wished and hoped to put everything of the past right. A spokesperson of our National Department of Health said at this meeting that the language problem was more apparent than real, for two reasons:

1. There are increasing numbers of professionals from a wider range of academic backgrounds, and
2. There was six-week course which could be undertaken by health professionals which would render them fluent in an indigenous language.

The fact is that though South Africa's workforce is changing fast it cannot now meet the needs for language access for our entire population, nor is it remotely possible for people to become fluent in another language within a period of six weeks. I did not know at that time nor do I know now whether this argument was made by the Department of Health spokesperson from a position of ignorance or more cynically as part as a stonewalling attempt by government. But I

could also see in this statement the wish that the problem was solved, a desire for complacency, indeed, an apparent complacency which may well mask the anxiety we all feel when faced with overwhelming needs. How can we afford proper linguistic access to services, government officials must think, when we have so many other needs, needs which are easier to measure and seem more pressing? Do we choose, for example, between a rapid rollout of antiretroviral therapy or paying for culturally and linguistically competent care?

The choice I am suggesting here is, of course, far less stark than would appear. We know from the vast literature on this that adherence to any kind of treatment (a vital issue in contemporary southern Africa in the context of antiretroviral therapies for HIV/AIDS) depends heavily not only on the availability of drugs but also on the quality of partnership between provider and consumer. But how do we or should we position ourselves in making the tough choices in weighing up the hard stuff of drugs against the soft stuff of cultural competence? Of course we need both, ideally, but we can't have everything. It is instructive in this regard to look a little more carefully at the question of voluntary counselling and testing in the context of HIV in low- and middle-income countries. There is good evidence that voluntary counselling and testing (VCT) can work in the context of carefully conducted research where there is good infrastructure and good professional support.⁹ This research, however, tells us almost nothing about the implementation of VCT in practice, and in fact Rohleder and Swartz found that VCT counsellors reported being marginalized in the real world of the health system. Because of the extent of the epidemic, the VCT counsellors with whom we worked were all lay counsellors. They were inserted into an overstressed, rigid health system, with no career path or structure, a system which is extremely task-oriented. What happened in practice? According to our data, professionally qualified staff resented their presence, saw what they were doing as a distraction and epiphenomenal, and even undermined the work. The counselors had no dedicated physical space in which to work – some working literally in the toilet with clients as there was no other place to see them. On one occasion, a counsellor reported, she was counselling a client and had just revealed the client's HIV-positive status. The client was silent for a while with shock and grief. In this silence, the professional nurse responsible for the allocation of physical space in the health facility knocked on the door, shouting to the counselor to hurry up with the work and not to waste time because the room was needed for other purposes.

If this is not an example of the need for looking at the organizational level when we think about cultural competence, I don't know what is, but the example also raises a very difficult question at another level. What is it with this insistence on VCT anyway? How do we know that VCT delivered under such circumstances is more valuable than, for example, accessibility on the basis of language in health care in general? Why are we spending such a lot of money on VCT when there are so many other needs? I do not wish to be critical

of VCT at all, or the wonderful work done by many counsellors and the people who support and train them, but the fact is that we don't know whether VCT works or not in the real world of the health systems, whereas we have quite a lot of evidence of the harm that can be done to both consumers and providers by a service which is hindered by language barriers. So what is going on here? It is certainly not unusual for practices which are unsubstantiated by 'evidence' as narrowly understood to be taken on and reproduced by health care systems, and indeed much of health care remains in the untested domain. We do what we can. But isn't there something strange about a systemic reality where basic counselling is completely unavailable to the vast majority of South Africans – it just does not exist in the public health system or the NGO system to any but the most tiny degree – but on the other hand where we insist on counselling everyone who has an HIV test? Surely we need to think about the insistence on HIV counselling ahead of good effectiveness data, and in a sea of nonprovision of other counselling services, we need to think about what this can tell us about the culture of our health system.

In this regard a number of points need to be made. South Africa is by no means unique in insisting on mandatory counselling of people in the context of HIV testing. This is an international phenomenon. HIV cannot be cured and is the most serious epidemic in the world at present. If we are completely honest, even in the context of ARV roll-out we do not as yet have enough longitudinal data from low-income settings on the extent to which it will be possible to manage HIV more as a chronic condition than as an ultimately fatal illness. HIV is closely associated with two uncomfortable issues – sex and death. And for different reasons, these scare us – scare us all, not just South Africans. So is there a possibility that the insistence on VCT may be a rigid and highly ritualized attempt as health care organizations to control our anxieties about a really anxiety-provoking situation – a deadly epidemic transmitted largely by sexual activity? Have our health systems, with complicity of well-meaning mental health professionals, myself included, adopted a cultural practice which is at least in part an obsessional ritual which keeps us busy and gives us something to do while we stare deadly sex in the face?

I am not suggesting here that VCT may not be useful (in fact, I think it probably is, in very many cases). But I think that if we ignore the ritualized nature of aspects of many health care organizations in many countries to the epidemic, we lose a dimension of thinking about organizational culture which goes beyond the usual confines of thinking about whether our services are equally open to everyone regardless of age, gender, race, class, ethnicity, disability, sexual orientation, and so on. There is something more fundamental going on here, in the way we ritualize aspects of what we do to protect our sense of who we are – to make us feel that we are competent in the face of our anxieties (whether specifically culturally competent or not).

In suggesting that there may be a defensive component to organizational culture, I am not saying that this is all bad – in fact,

defences are necessary for organizational survival as much as we all as individuals need defences. But just as it may be helpful to explore the ways in which any person's defensive patterns help and don't help (and it is always a complex mix of things), it may be equally useful to look at organizations in this way. Things get really interesting, furthermore, when we start layering the usual suspects in the cultural competence field onto this way of seeing organizations and, indeed onto thinking about how we create knowledge about health, illness and well being. I shall now discuss two examples, both from the HIV field.

Until recently, I was lucky enough to be part of a team working to develop a preventive vaccine against HIV in South Africa, and I led a group working on social science issues surrounding HIV vaccine development. The job of this group was largely around questions concerning Phase III vaccine trials. If the laboratory scientists come up with a vaccine with proven safety and promising immunogenicity, the next step will be to take the vaccine into large-scale population-based testing. This means setting up vaccine trials with large numbers of people who are HIV negative but are at risk of HIV/AIDS. We then give the candidate vaccine to some of the people and a placebo to the others. We follow them up and see whether the risk of seroconversion is lower in the group getting the candidate vaccine. This process is both ethically and logistically complex and hard to do in a way which adequately protects people and which promotes their rights. This question intersects with uncomfortable social realities. We know from good epidemiological work that the incidence rate for HIV is probably highest by quite a long way in poor, informal settlements in South Africa, and lowest, though still very high, in 'Indian' and 'white' South Africans. In fact, amongst the best incidence data that we have suggests that people living in informal settlements (these are poor, overwhelmingly black people) are over seven times more likely to contract HIV over a two-year period than are white South Africans.¹⁰ If the incidence rate in a particular community is seven times that in another community, it makes good epidemiological sense to go into the community with the highest incidence rate as this allows us to recruit fewer people into a trial that will have the statistical power to help us work out whether the candidate vaccine works or not. This can translate into much lower costs for the trial, or getting results much earlier, both of which are good news if we want an affordable vaccine as soon as we can. But what does this mean, in practice? It means, once again, being the scientists who focus their work on the most marginal, the weakest, and, to be frank in the South African context, on a particular sector of the black population. Images of Nazi scientists, of eugenics, of the Tuskegee experiments, lurk around all of this. In this context more than one influential commentator has suggested that it is not acceptable to test the vaccines only on black South Africans, but that testing must be done on whites as well. Luckily there is a largely white MSM (men who have sex with men) cohort as part of the project but here again we are talking about another oppressed, marginalized group. But this raises, once again, a very difficult cultural competence

issue: is it in the context of a devastating epidemic more culturally competent to be doing something which allays all our lurking fears about racist science but makes no epidemiological sense and can significantly delay the production of a vaccine? Or is it in this context more culturally competent to face head on the unpleasant reality that in order to get the work done with the best chance of the quickest and best impact, we have to manage all our anxieties and worries about the racial politics of the work, but go for where the incidence is dramatically higher?

To me, the second option is clearly the preferable one, but it requires a kind of political will and courage which cannot be assured in the current South Africa, especially given the ongoing difficulties with our Minister of Health's approach to the epidemic, in flagrant violation of our country's excellent AIDS policies. There is no question at all in my mind that part of why our Health Minister implies without any scientific evidence at all (and in the face of some evidence to the contrary) that garlic, African potato, etc., are effective tools against AIDS, is that she is performing a kind of cultural identity politics – taking on the mantle of the essentialised African fighting western oppression and the pharmaceutical industry – and being irresponsible in terms of the epidemic.¹¹ More importantly for the current argument, though, is the point that we are working in the context of what Catherine Campbell has identified as a lack of political will when it comes to HIV/AIDS.¹² This bigger political picture – understanding it, engaging with it, doing what we can to create the political environment most conducive to wellbeing – is another level with which we have to engage if we are serious about cultural competence.

Let me turn now to the second area in which anxiety about the HIV epidemic is layered on other issues of our difficulties with difference and diversity. At issue here is the question of HIV risk for disabled people. We know from a variety of studies and from the work of Groce¹³ that disabled people are at greater risk than others of being sexually abused, being poor, being poorly educated and poorly educated about sex in particular, and of not marrying and having a steady partner because of stigma

All of these suggest that HIV risk for disabled people is probably much higher than for the general population, but there is almost no good research world-wide on disability and HIV-risk, and we know very little about what works and what doesn't in terms of HIV prevention for particular groups of disabled people. There is some work in this area. but the point for this discussion is that if we are serious about cultural competence we must also think about skews in the way in which knowledge about health issues come into being – what are our cultural concerns doing to help us to stop thinking about things which are hard to think about? It is probably true to say that many people do not like to think about disabled people being sexual or having sex. This general reluctance to think about disability and sexuality is at least part of what drives the higher rates of sexual abuse of disabled people. But, more importantly for this discussion, it may also be what may drive an

international collusion against looking at disability as a vector in the spread of the AIDS epidemic. We need to unpack this kind of thing and to be brave enough to take it on. And making pamphlets in many languages about HIV and disability, though potentially helpful, is not enough – we need the political will and the personal courage to effect a cultural change in the way we look at the epidemic. We even need the courage to take on the hero of the AIDS epidemic in South Africa, a little boy called Nkosi Johnson who subsequently died of AIDS. At the 2000 AIDS conference he ended his much quoted speech in the following way:

I want people to understand about AIDS, to be careful and respect AIDS. You can't get AIDS if you touch, hug, kiss, or hold hands with someone who is infected. Care for us and accept us – we are all human beings. We are normal. We have hands. We have feet. We can walk, we can talk, we have needs just like everyone else. Don't be afraid of us. We are all the same!

This is a great speech but it is also a speech which is deeply disablist, and which feeds into the glamourization and commodification of AIDS in the context of media campaigns which locate HIV-prevention within advertising culture and the body fascism which is so much part of our visual culture.

Concluding comments

I have thus far made two related points. First, if we are serious about cultural competence we have to address the related question of our visceral experiences of cultural incompetence – the difficult, secret silences which can become even more shameful and hard to think about in the context of more and more bells and whistles of practice excellence in the field of cultural competence. Second, and this point links with the first, there is a broader political dimension to all this, a dimension which is at the same time more powerful and more hidden than the obvious one of what we do daily in our work – it is simultaneously everywhere and nowhere. If we are serious about cultural competence, we need to look for the silences around culture and competence, silences which are hard to hear or see, because they are, I would argue, both internal and structural in the political sense. We live these silences out but it takes a particular way of looking, and indeed a particular courage to turn these silences into speech.

There is another kind of work that needs to be done – work which is not complex, but work which involves looking very closely at people's lives. Siyabulela K and Madeleine Duncan¹⁴ have done groundbreaking work about giving voice to people with psychiatric disability in South Africa, and part of cultural competence is no more and no less than allowing the space for people's voices to be heard.¹⁵ What does it mean to be poor and psychiatrically disabled in South Africa? It is worth quoting at some length from the words written by Siyabulela K about his own experience:

MY MENTAL ILLNESS IS ABOUT...

Becoming so lonely, worried, anxious, being upset and being

uncertain about the future. I also think that it is that time in your life when you became unconfident and unsure of yourself. It is that time when you forget how to look after yourself and not being in control of your life for example forgetting to comb your hair, forgetting to wash as if you are instructed to kill somebody or forgetting to zip your trousers or being not totally sure of whether you look perfect or imperfect. Sometimes you see someone wiping his/her mouth and you also do likewise.

REASONS FOR MENTAL ILLNESS

Most people's mental illness is caused by growing up under too much hardship and failure to keep promises by people you trust too much. I also think the cause was a long history of hunger and poverty which the family has. Other mental illnesses are caused by constant use of drugs which can change the way you view life and people around you. I think for others it is caused by high divorce rates which leave children being lost with not enough guidance from the single parent as a result of separation from the other parent. If we live with mother we are going to miss father as our role model/father figure as it is believed that girls grow towards the direction of their mother and boys towards the direction of a father, and girls answerable to their mother and boys answerable to their father, and vice-versa.

BEING POOR

According to our culture, they believe that living in hunger and poverty could lead to revolting, being uncontent and being rebellious against one another due to hardship with no-one taking a stand for each other and also defying authority. I think mental illness it could lead to more bad things and misfortunes in your life, living without doing your customs and traditions.

Being poor affects me because I cannot always get what I need at the time I want it, but somehow it helps as it forces us to prioritise. Start with important things first and end with those least important. It is a little better since the Rand regained strength and by Government taking a watchful eye on prices as before you can't afford to buy anything else other than food with my Disability Grant which is much better than before.¹⁶

There is nothing more eloquent than the simple testimony of the insider voice. There is much in the detail of being able to listen to what people have to say.

The transcultural psychiatrist H B M Murphy said in the 1970s that "transcultural psychiatry should begin at home".¹⁷ By this he meant two central things. First, good transcultural psychiatry (or cultural competence) is no more and no less than good practice in general. Second, good transcultural psychiatry (or good cultural competence) requires us to take a critical look at ourselves and at the décor and the ambience of our own internal home. This is no more and no less than what Rob Barrett was asking us to do when he bravely

turned his anthropological gaze not just on 'other cultures' but on western psychiatric practice itself.¹⁸ Knowing the ways in which we are, or feel, incompetent may help us more than imagining that competence is purely a matter of the skill of knowing about the 'other'.

ENDNOTES

- ¹ Constantine MG, and Sue DW, *Strategies for building multicultural competence in mental health and educational settings*, New York: Wiley, 2005.
- ² Daniels K and Swartz L, 'Understanding health care workers' anxieties in a diversifying world', *PLoS Medicine* Vol.4, no.11, 2007, : e319; Kai J, Beavan J, Faull C, Dodson L, Gill P, 'Professional uncertainty and disempowerment responding to ethnic diversity in health care: a qualitative study', *PLoS Medicine*, Vol.4, no.11, 2007. e323.
- ³ Kai et al, *ibid*.
- ⁴ Sinason V, *Mental handicap and the human condition: New approaches from the Tavistock*. London: Free Association Books, 1992.
- ⁵ Watermeyer B, 'Blindness, attachment and self: Psychoanalysis and ideology', *Free Associations*,49, 2002, pp.335-352. Watermeyer B. 'Disability and psychoanalysis', in Watermeyer B, Swartz L, Schneider M, Lorenzo T and Priestley M (eds) *Disability and social change: A South African agenda*, Cape Town: HSRC Press, 2006, pp.31-46.
- ⁶ Christian R, Mokutu M, and Rankoe M, 'Black students' experiences of training at an historically "white" institution', in Swartz L, Gibson K and Gelman T (eds) *Reflective practice: Psychodynamic ideas in the community*, Cape Town: HSRC Press, 2002, pp.33-44.
- ⁷ Van der Walt H, 'Too close for comfort: Emotional ties between nurses and patients', in Swartz L, Gibson K and Gelman T (eds) *op. cit.*, pp.72-84.
- ⁸ *Ibid*.
- ⁹ Rohleder P and Swartz L, 'What I've noticed what they need is the stats: community counsellors and HIV', *Aids Care*, vol. 17, no. 3, 2005, pp. 397-406.
- ¹⁰ Shisana O, Rehle T, Simbayi LC, Parker W, Zuma K, Bhana A, Connolly C, Jooste S and Pillay V, *South African national HIV prevalence, HIV incidence, behaviour and communication survey*, Cape Town: HSRC Press, 2005.
- ¹¹ Swartz L, 'Indigenous issues, lower-income countries, and mental health promotion. Invited Plenary Address', in E. Berger (ed) *From research to effective practice. Proceedings of the Third World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders*, September 15-17, 2004. Rockville: United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- ¹² Campbell C, *Letting them die: Why HIV/AIDS prevention programmes fail*, Cape Town: David Philip and London: St Martins Press, 2003.
- ¹³ Groce N, 'Adolescents and youth with disability: Issues and challenges 2003', <http://www.dodd.nl/default.asp?action=article&id=2150> [accessed on March 14, 2006]; Groce N. 'HIV/AIDS and people with disability', *The Lancet*, Vol. 361, 2003, pp.1401-1402; Groce N, *HIV/AIDS and disability: Capturing hidden voices, Report of the World Bank Yale University Global Survey of HIV/AIDS and Disability*, Washington: World Bank, 2004, <http://siteresources.worldbank.org/DISABILITY/Resources/Health-and-Wellness/HIVAIDS.pdf>, [accessed on March 12, 2005]; Groce NE. 'HIV/AIDS and individuals with disability', *Health and Human Rights*, Vol. 8, no.2, 2005, pp.215-224.
- ¹⁴ Siyabulela K. and Duncan M, 'Psychiatric disability and social change: An insider perspective', in Watermeyer B, Swartz L, Schneider M, Lorenzo T and Priestley M (eds) *Disability and social change: A South African agenda, op. cit.*, pp. 291-310.
- ¹⁵ *Ibid*.

¹⁶ Ibid, pp.296-297.

¹⁷ Murphy HBM, 'Transcultural psychiatry should begin at home', *Psychological Medicine*, Vol. 7, 1977, pp.369-371.

¹⁸ Barrett RJ, *The psychiatric team and the social definition of schizophrenia: An anthropological study of person and illness*, New York: Cambridge University Press, 2006.