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CULTURAL COMPETENCE - A NECESSITY FOR THE MENTAL HEALTH PROFESSIONALS

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Abstract: *The impact of cultural elements on mental health professionals is so powerful that interculturalism is seen as a defining feature of current psychology. Moreover, interculturalism is considered to be "the fourth paradigm" in the field of clinical psychology, along with psychoanalysis, behaviorism and humanism. This study addresses the importance of acquiring a cultural competence in order to achieve and train some of the skills to communicate effectively in a pluralistic democratic society. A lot of European documents underlining the importance of intercultural competence to be active citizens. We will analyze the three basic ingredients of cultural competence required by the clinical psychologist and the psychotherapist: self-awareness of one's own culture, knowledge of other cultures, and the development of culturally appropriate clinical skills. We will discuss the perspectives of several multicultural experts in the field of mental health, as well as the specificities of the Romanian cultural space. Special attention will be paid to the Romanian culture-bound syndromes (the evil eye and the nervous breakdown), and to the variables that clinical psychologists should consider when they appreciate their clients' backgrounds.*

Keywords*: clinical work; cultural competence; Romanian culture-bound syndromes*

1. GENERAL CONSIDERATIONS

In the present study, culture is understood as a frame of reference and, in a broad sense, includes ethnographic variables (ethnicity, nationality, language, religion), demographic variables (age, gender, place of residence), status variables (social, educational, economic) and affiliations (formal and informal). The emphasis is on the "gained experience" of the psychology services beneficiary, a perspective that proposes an inductive, reflective, meaning-focused and contextualized learning method.

In the context of a wide range of social and cultural diversity, a "cultural competence" is required from the mental health specialist. He is often confronted with people belonging to different populations. A common theme in almost all conceptualizations of cultural competence is the practitioner's need to gain a more complete and deeper understanding of the client's "vision on the world" and "cultural frame of reference". Numerous authors have written practical guides for working with clients/ patients belonging to diverse populations (Pope-Davis & Coleman, 1997; McGoldrick, Giordano & Garcia-Preto, 2005; Sue, Ivey & Pedersen, 1996).

In order to make a distinction between universality and cultural specificity, Dana (2005) proposes the terms of *ethic* and *emic* that derive from the field of linguistics from *phonetic* and *phonemic*. The phonetic term is used for those sounds that are common to all languages, and the phonemic for those sounds that are specific to a particular language. The *ethic* perspective, which is prevalent in the early years of psychology, emphasizes the similarities between people, while it attaches no importance to the cultural differences between them. The *emic* perspective differs from the ethic one by recognizing and emphasizing specific cultural norms. By adopting the emic perspective, as a result of the multicultural boom, the specialist takes into account the customer's feelings, thoughts and behaviors from the perspective of his client culture rather than impose the norms of another culture on the client. Through an empathic effort, persons from different cultural groups should be understood "*in their language*". "With respect to empathic understanding, it may prove helpful for a practitioner to comprehensively respond to a client by maintaining an awareness of a person's functioning from multiple cultural perspectives (Clark, 2007:25).

2. CULTURAL DIVERSITY OF THE BENEFICIARIES OF PSYCHOLOGY SERVICES IN ROMANIA

Along with the Romanian community, there are various other ethnic communities with specific cultural traditions. Transylvania, Banat, Bucovina and Dobrogea are the regions with the highest ethnic diversity in Romania. According to the 2011 census, the minority population represents about 11% of the total population of 20.1 million inhabitants. The most important minorities in Romania are Hungarian (about 58.9% of all minorities), followed by Roma (29.8% of minorities), Ukrainians (2.44% of minorities), Germans (1.73%), Turks (1.33%), Russian-Lipovans (1.13%) and less than 1% (each) of minorities: Tatars, Serbs, Slovaks, Bulgarians, Croats, Greeks, Jews, Italians, Poles, Czech and other minorities.

On the other hand, a phenomenon we face is that of the Romanians' migration to Europe. According to a recent United Nations report, our country is on second place in a world's top of migration. More than 3.4 million Romanians are registered as working abroad or settled there with their families (Italy, Spain, England, etc.). Upon their return to the country, the Romanian mental health specialist must take into account the phenomenon of acculturation manifested in their case. Being in a new cultural environment, they respond in a wide variety of ways either by adopting the new elements of the new culture or by retaining the elements of their culture of origin. In recent years, we have seen a significant increase in the number of psychoterapy sessions offered to young people going to study in the West, confronted with various symptoms of depression and/or anxiety.

In the context of current multiculturalism, it is necessary to take into account the specific cultural elements of clients who require psychological help and integrate them into our theories and therapies. Only in this way clients will feel truly understood. We promote in this context the idea of a "*bespoke therapy*" in which the shape, cadence, style of psychotherapy, as well as the cultural aspects of the client will be taken into account in order to be adapted to the needs of each individual client. The basic question is like: "*Who or what better suits this person, couple, family or group in terms of their cultural aspects*?". The mental health specialist will need to determine exactly what type of relationship and therapeutic strategies are best suited to each case and under what conditions. The problem is how to match or adjust the treatment to the client and not vice versa.

2.2 Culture-bound Romanian syndromes: the nervous breakdown (*crizele de nervi*) and the evil eye (*deochiul*). From a clinical perspective, cultural differencies have been shown to bias the accuracy of a therapist's diagnostic impressions of clients form diverse cultures (Clark, 2007:26). Ethnographic epistemology comes to broaden the understanding of the client's cultural frame of reference and provides a way to explore the complexity of that experience from the point of view of those who live it. From this perspective, we will analyze two syndromes specific to our cultural environment: the nervous breakdown and the evil eye in Romanians.

The nervous breakdown is characterized by symptoms of intense emotional upset, including: acute anxiety, anger or grief, uncontrollable shouts or screams, depression, crying, tremor, chest heat sensation, verbal and physical aggression. A general feature of the nervous breakdown is the sense of being out of control. Patients describe the emergence of these crises as a direct result of a stressful event relating to the family, such as the news of the death of a close relative, conflicts with their partner or children, an accident involving a family member. In a small proportion of individuals, the nervous breakdown doesn't seem to be triggered by any particular event. In these cases, their vulnerability to losing control comes from the accumulated experience of suffering.

Related conditions in DSM-5 (2013) with the *nervous breakdown* are: panic attack, panic disorder, major depressive disorder, dysthymia, other specified or unspecified dissociative disorders, conversion disorder. The phrase "suffering from nerves" ("*a fi bolnav de nervi*") by manifestation of a nervous breakdown, is associated especially with anxiety and depression. Related conditions in other cultural contexts are: *nevra* to the Greeks, *nierbi* to the Italians, *crise de nerfs* to the French, *ataques de nervios* to the Spanish, short episodes of *blaking out* in USA.

Another syndrome specific to the Romanian cultural environment is *the evil eye ("deochiul")*. It can be a cultural explanation for various medical and psychiatric disorders. In this explanatory model, excessive admiration combined with envy and malice cause people to harm their enemies by sending illnesses such as depression, headaches, nausea, tired sleep or insomnia, the inability to perform activities of daily living. In the etiological model it is admitted that the illness can be caused

by the envy and malice of some people, provoked by the victim's economic success as evidenced by a new job or expensive purchase. It is believed that if a person wins, this will cause a loss to another, and for this reason the visible success of an individual makes him vulnerable to the evil eye. The best cure, in the unanimous sense of the experts, is the red thread that protects you from the evil eye, the wearing of gold ornaments, the wearing of a garment inside out or a clove of garlic in your pocket. Related conditions in other cultural contexts are: *maladi moun* (literally "humanly caused ilness" or "sent sickness" present in Haitian communities), the "*evil eye*" in the Spanish (*mal de ojo*) or Italian (*mal'occhiu*) cultural space. The acute onset of new symptoms or an abrupt behavioral change raises the suspicions of a spiritual attack. Therefore, an attractive, rich and intelligent person is perceived as vulnerable. Related conditions in DSM-5 (2013) are: panic attack, conversion disorder, other specified or unspecified dissociative disorders, major depressive disorder, delusional disorder – persecutory type, schizophrenia with paranoid features.

Mental health specialists from countries where there are important Romanian communities can take into account the two syndromes analyzed above, appearing with a certain recurrence in patients' complaints about their state of physical and mental functioning.

2.3 Cultural competence. C The cultural competence equation includes two factors: self-awareness of one's own culture and knowledge of the cultural background of our clients (Pomerantz, 2011: 66-74). Cultural competence is built from the learning of one's own culture, not just where our parents and grandparents came from, but also the values, assumptions and biases that arose as a result of all cultural influences. The psychologist will also have to realize that differences between people are not necessarily deficiencies, especially if these differences are common and valued in the client's own cultural group. Instead of glossing over the differences between themselves and their clients, the specialists will have to explore their own reactions to these differences and the discomfort that these differences create upon them (Greene, 2007: 47-63). Of course, the process of cultural self-awareness can be difficult and unpleasant for the psychologist, as it may require to admit some belief system that he pretends to have rather than have. We refer here to racism, sexism, heterosexism, classism, ethnocentrism, etc.

Of course, being aware of your own culture is a first step, and the next one is knowing the cultural background of our clients (through reading, direct experience, relationships with people who are part of other cultures). Cultural knowledge should include not only the lifestyle of members of a culture, but also the history of the group, especially major political and social issues. A mental health specialist who does not recognize historical realities and their potential impact on his clients could make misinterpretations that are detrimental to the therapeutic relationship. Of course, we do not have to rely on the premise that each individual is typical of his cultural group. Although the cultural group has a collective tendency, its individual members may vary significantly from this central trend. It would be a bias to consider that a member of a cultural group has all the common features of a group. The specialist will appreciate the rules of the social group, but also the **heterogeneity** inherent in each culture. One aspect of heterogeneity is the phenomenon of **acculturation** (Organista, Marin and Chun, 2010; Rivera, 2010). When individuals are in a new cultural environment, they will respond in a variety of ways, especially with the adoption of new elements of the new culture or the retention of elements that are part of their original culture. Four specific acculturation strategies have been identified (Berry, 2003: 17-37; Rivera, 2008: 73-91): *assimilation*, in which the individual adopts elements of the new culture and abandons those from the original culture; *separation*, in which it rejects many elements of the new culture and retains much of the original ones; *marginalization*, in which it rejects both cultures and *integration*, in which it adopts many elements of the new culture and retains many other elements of its culture of origin. So, there is a remarkable diversity within any cultural group. Knowing that Anna came from Greece to Romania 15 years ago does not tell us much about her cultural identity. To what extent has she adopted the central trends of Romanian culture? To what extent does she carry with her the Greek cultural traditions and beliefs? The culturally competent specialist makes efforts to identify his client's strategies of acculturation in order to gain a deeper understanding of his client's unique lifestyle.

3. CONCLUSIONS

In the context of current multiculturalism, it is imperative that the mental health specialist acquires appropriate assessment and treatment

strategies. The approaches and the therapeutic techniques used for the change must be consistent with the values and the life experiences of his client. Clients in the Romanian cultural space respond well both to action-oriented therapies with a short-term focus as well as to approaches that focus on getting *insight* about their psychological problems.

A dominant note in the mental health services offered to the Romanian clients is represented by the therapeutic relationship factors: empathy, authenticity, respect, warmth, congruence and concreteness (Dimitriu, 2014). Effective psychotherapy begins when the specialist internalizes and uses these basic features of the therapeutic relationship. In addition, the Romanian therapist must show adaptability and flexibility in the use of conventional therapeutic techniques. In countries where there are significant communities of Romanians (Italy, Spain, England, France, Germany, Austria, the Netherlands, Finland, the USA, etc.), the mental health specialist's assessment includes the following elements: resident or citizen status; degree of fluency in speaking "*standard*" English or other languages; access to community resources; extent of family support or disintegration of family; level of education; changes in social status as a result of coming to other country (immigrant); professional history and level of stress related to the phenomenon of acculturation. Last but not least, the emphasis on empathy, authenticity, respect will be an important positive predictor of success in the therapeutic relationship. Effective therapy with Romanians begins when the therapist carefully internalizes and uses these basic characteristics in counseling settings.

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