PERCEPTION OF MULTICULTURAL COMPETENCE AMONG GRADUATE STUDENTS OF PSYCHIATRY AND CLINICAL PSYCHOLOGY IN THE DEPARTMENT OF PSYCHIATRY, ADISS ABABA UNIVRSITY

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Abstract

This study explored the perception and understanding of 13 graduate students of psychiatry and clinical psychology trainees who are studying in department of psychiatry, college of health science, Addis Ababa University. Based on a qualitative analysis, many of this study participants noted that aspects of being a multiculturally competent counselor included open-mindedness, flexibility, knowledge and awareness of cultural issues, skillfulness in making cultural interventions, self-awareness, and exposure to broad and diverse life experiences. Most of the participants also stated that a barriers to being a multiculturally competent mental health care providers includes lack of practitioner motivation, personal bias or attitude, lack of knowledge, language barrier and lack of experience.

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CHAPTER ONE

INTRODUCTION

1.1 Background

An individual's cultural background determines every aspect of illness, from linguistic or emotional expression (Helman, 2007; Lewis-Fernandez, 1996) to the content of somatic complaints (Goldber & Bridges, 1988) and delusional or hallucinatory experiences (Kim, 2006; Cowen, 2011). Cultural factors influence Cause, course and outcome of major psychiatric disorders (Kleinman, 1988; Kirmayer, 2001; Littlewood & Lipsedge, 1997). Dysfunctional behavior is the important component in diagnosis and the social and cultural component are key issues in identifying dysfunctional abnormal behavior (Kirmayer & Young, 1999). Perception and practice of health is unique for different cultural and ethnic groups based on their ecocultural adaptation (Weisner, 2002). Culture is defined as a set of behavioral norms, meanings, and values or reference points utilized by members of a particular society to construct their unique view of the world, and ascertain their identity. It includes a number of variables such as language, traditions, values, rituals, customs, etiquette, taboos or laws, religious beliefs, moral standards and practices, gender and sexual orientation, and socio-economic status (GAP, 2002). Cultural product such as common sayings, legends and folklore, drama, plays, art, philosophical thoughts and religious faith reflects the variables of culture (Tseng & Strelzer, 2006). Culture is learned through active teaching and passive acting, it is shared among similar group members, have different sets of beliefs and practices that guide different areas of individuals and social life,

is dynamic through changing environment and symbolic that represent something special to the group. (Chowdhury, 2012).

Cultural competence is the skill of an ability to function or interact effectively with individuals from different cultural heritage (Wilson, Ward and Fischer 2013). Multicultural competence in a psychological setting refers to the continuous process of psychologists ability to work effectively within the cultural context of the client which consists of the individual, family and the community(Chowdhury,2012). Studies shows that psychologists who are multicultural competent are more effective in addressing their clients need (Chowdhury, 2012).

A multiculturally competent mental health practitioner is effective in treating clients who have different cultural, ethnic, racial, sexual, religious, ecological and educational backgrounds because they have the ability to adapt to different cultural contexts (Chowdhury, 2012). Empirical data suggest that a lack of cultural competency increases misdiagnoses, inappropriate treatment choices, miscommunication between healthcare professionals and patients, errors in clinical practice, poor quality of care and premature termination of treatment (Park et al, 2011) . In contrast, culturally appropriate mental health services increase utilization, shorten the delay between onset of symptoms and contact with the mental health system, and lower the rate of premature termination (Chow 2002, Bhui et al. 2005).

1.2 Statement of the problem

According to UN Ethiopia is estimated to have around 104 million population (DFAT, 2017). There are more than 80 ethnic groups in Ethiopia. In Ethiopia religion plays a great role in everyday life of the society. According to the US State Department's 2015 International Religious Freedom Report (the latest available), around 44 per cent of the population belongs to the Ethiopian Orthodox Church, 34 per cent are Sunni Muslim and 19 per cent belong to Christian evangelical and Pentecostal groups. There are also

small numbers of Catholics, other Christian groups, Jehovah's witnesses, Jews and followers of traditional indigenous religions. There is also a group of around 800 Rastafarians living on land set aside for them by Emperor Haile Selassie in the 1940s (DFAT,2017). In addition according to UNHCR, Ethiopia hosts nearly 840,000 refugees in total across the country (DFAT, 2017). As Multicultural competency is the ability of professionals to acknowledge differences and interacting effectively with various groups of people and Ethiopia has a huge diverse population in terms of religion, ethnicity and so on, it is crucial for professionals to possess this competency. Researches show that multicultural competence is becoming the fourth force in the field of psychology next to psychoanalysis, behavioralism and humanism. It enhances the existing model through engraining them with sensitivity and awareness of how they can be best applied to individuals of different cultural backgrounds. Unfortunately, little is known about the current understanding and practices of multiculturally competent service among the Ethiopian mental health care providers because there is lack of empirical literature exploring such topics in Ethiopian context.

1.3 Significance of the study

Mental health and illness is a set of subjective experience and a social process and thus involves a practice of culture-congruent care (Chowdhry, 2012). The purpose of this study is to give some insights about how psychiatry residents and clinical psychology students understand multiculturalism because the ethnic and cultural diversity of Ethiopian population calls for awareness and understanding of multicultural competence and the quality of the service given depend on multicultural competence. So this study will help to give awareness about the quality of the service given by the psychiatry residents and clinical psychologists in different sites regarding multiculturalism.

1.4 Research question

What are the perceptions of psychiatry residents and clinical psychology trainees about multi cultural competence?

1.5 Research objectives

General objective

Exploring the perception of graduate students of psychiatry and clinical psychology about multicultural competence, the importance of having multicultural competence and factors that affect multicultural competence

Specific objectives

1. Exploring the perceived meaning of multicultural competence by graduate students of department of psychiatry, school of medicine, college of health sciences, AAU
2. Exploring the perceived significance of possessing multicultural competence
3. Exploring perceived factors that can affect multicultural competence

CHAPTER TWO

Literature review

2.1. Culture

Culture is defined as a set of behavioral norms, meanings, and values or reference points utilized by members of a particular society to construct their unique view of the world, and ascertain their identity. It includes a number of variables such as language, traditions, values, rituals, customs, etiquette, taboos or laws, religious beliefs, moral standards and practices, gender and sexual orientation, and socio-economic status (GAP, 2002). Cultural product such as common sayings, legends and folklore, drama, plays, art, philosophical thoughts and religious faith reflects the variables of culture (Tseng & Strelzer, 2006). Culture is learned through active teaching and passive acting, it is shared among similar group member, have different sets of beliefs and practices that guide different areas of individuals and social life, is dynamic through changing environment and symbolic that represent something special to the group. (chowdhury). Swartz (1998) sees culture as “a collection of guidelines, both implicit and explicit, which individuals inherit as members of a particular society, which they internalize in relation to others, spiritual powers or gods, and the natural environment” (p.6). the author also stresses that the social climate is always changing, thus social rules are often changing. This implies society cannot remain stagnant. Corin (1995) says culture informs view of the world, the very view in which we are engaged in assigning meaning to personal and collective experiences.

2.2. Multicultural competence

Multicultural mental health care emphasizes the difference between the professional and the client in terms of ethnical backgrounds, gender, worldviews, national origins, social economic statuses, and sexual orientations (Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists (APA, 2003) defines multiculturalism as a recognition of “the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions” (p. 379).

Calvillo et al. (2009) define “cultural competency” as the “attitudes, knowledge and skills essential for working with individuals from a diverse population”. Furthermore, the authors explain the term as a continuous progression which includes accepting and respecting individual differences without exercising controls.

The dominant model of clinician’s multicultural competence is the tripartite model of Sue et al. (1992), which describes a particular collection of knowledge, skills and attitudes designed to characterize the culturally competent clinicians. These clinicians are those who are actively working towards increasing their understanding of their client’s cultural context and world view; creating and using culturally responsive client specific approaches and treatment strategies; and raising awareness about their own perceptions, attitudes and values and also how they can influence interactions with a client.

According to Ton et al. (2005) multicultural competency is a set of “culturally congruent strategies, behaviors, attitudes and policies used in cross-cultural situations”. It is described as a method in which the clinician actively seeks to achieve the capacity to act successfully within the cultural context of the client by keeping an open mind and using relevant skills and techniques.

Cultural competence provides the opportunity to explore the values and assumptions of the client and thus provide the opportunity to negotiate a stereotype-free treatment plan (Bhui et al, 2008). Sue and Sue (1999) listed six characteristics of culturally competent counselors: (1) awareness of sociopolitical forces that have impacts on clients, (2) awareness that differences in culture, social class, and language can be barriers to counseling, (3) awareness of the impact of worldviews, (4) awareness of how expertness, trustworthiness, and lack of similarities can influence clients' receptivity of counseling, (5) knowledge and skills about appropriate communication styles among different cultural groups, and (6) awareness of counselors' racial biases. The hearts of multicultural competence are attitude or belief, knowledge and skill.

2.3. Key components of multicultural competence

Arredono et al, 1996 identified three components. The first one is counselors awareness of own cultural values and biases. The professionals have enough awareness about how their own cultural background and experiences have influenced attitudes, values, and biases about psychological processes, recognize their sources of discomfort with differences that exist between themselves and clients in terms of race, ethnicity and culture. In addition culturally competent professionals have knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of normality/abnormality and the process of treatment. Furthermore culturally skilled professionals recognized their limit of competency and seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally different populations. The second is professionals' awareness of client's world view. culturally competent professionals is aware of their differences, the stereotypes they have about the other groups and positive and negative emotional reactions towards other group that may affect the therapeutic relationship. culturally

skilled professionals have knowledge about how personality formation, vocational choices, manifestation of psychological disorders, help seeking behavior, and the appropriateness of counseling approaches are the result of culture. Professionals who are aware of their own cultural values and biases and client's worldview can effectively deliver culturally appropriate intervention.

2.4 Historical overview of multicultural counseling and multicultural competence

Colonization played a great role for the development of multicultural counseling. Vontress was the pioneer to identify the challenges to work with African-American clients because of the intergenerational trauma and the difficulty to establish rapport with black client as a result of their intense emotional reaction against white people because of their lived experiences (Vontress, 1971). Vontress asserted that practitioner’s working in multi-cultural settings were at risk of potentially minimizing and/ or misunderstanding the client’s presenting concern, through over-focusing on one or more noticeable identity marker(s) such as: ‘race’, color, ethnicity, nationality or culture, at the expense of more pertinent symptoms and experiences related to their distress narrative. In 1970's initiatives was made to raise awareness on the relationship that exists between mental health and racism. Scholars and practitioners began to inquire inequity, misdiagnosis and cultural insensitivity in mental health provision. In 1980's multicultural scholars further asserted neglecting ethno-racial factors would lead to the provision of mental health services that were insensitive (Vontress & Epp, 1997). In 1990's multiculturalism was declared as the fourth force of psychology by pedersen. American psychologist association made it mandatory for professionals to reeducate and retrain as a part of revised ethical code. Recently the concept of multiculturalism encompass not only ethnicity and race but also gender, sexual

orientation(s), religion, social class, and disability status (Sue et al., 1992). The emergence of multicultural competence is included under the multicultural counseling movement.

2.5 Theoretical context of multicultural competence in mental health counseling

In the recent years, scholars have formulated various approaches and concepts to explain the role of multicultural competence in mental health counseling services. Most previous research identified multicultural competence theory as a crucial explanatory factor in assessing outcomes of mental health care. Collins and Arthur's research (2017) is a criticism of the historical notions related to therapy in cultural practice. They observed that if cultural competence approaches and methods are insufficient to accommodate diverse cultural communities the client would achieve fewer positive results. Additionally their study introduced a new theoretical model, called culture-infused therapy, seeking to establish a cooperative working partnership between the clients and clinicians. Moreover a research by Arslan and Rata (2013) reinforced the value of formulating more concrete and complex principles when engaging with people from different cultures, as generalizing principles of multicultural teaching from the majority culture is not rational. Such studies have shown that multicultural competence theoretical principles should be complex, as learning methods and techniques for cultural competence appear to be inefficient when reacting to multicultural context issues.

Numerous scholars have also studied relational-cultural theory as a primary approach to multicultural competence in mental health care. Relational-cultural theory, according to a study by Duffey and Trepal (2016) emphasizes the fostering of relationships through the development of separation and individualism within human growth. The definition emphasizes the approach to successful mental health needs not only strong bonds between counselor and client, but also

durable bonds that allow counselors in mental health to build multicultural skills through long-term contacts with patients.

Sehgal, Saules, Young, Grey, Gillem, Nabors, and Jefferson, (2011) noted that the counselors' multicultural competence is determined by experience and the ability to apply trained knowledge and skills to clients.

2.6 Relationship of therapists' multicultural competence to psychotherapy process and outcome

Recent literature shows that higher ratings on multicultural competence of therapist are associated with more favorable ratings on process and outcomes of treatment. Results from multicultural studies have typically shown that higher client ratings of multicultural competence of therapists are positively related to important therapeutic process including working alliance, client satisfaction, general counseling competence, and session impact (Tao and Owen, 2015) .

Working alliance refers to the partnership between the therapist and the client and to the involvement of both parties in directing the therapy process (Bordin, 1979; Horvath & Greenberg, 1989; Horvath & Symonds, 1991). Overall, associations between client-rated alliance and multicultural competence ranged from moderate to significant, suggesting that higher ratings of multicultural competency of therapist's were positively correlated with ratings of alliance (Tao and Owen, 2015). Session impact refers to evaluations of clients' psychotherapy sessions, including immediate consequences and mood after session (Stiles and Snow, 1984). An empirical analysis of the profundity of the session and its connection with the experiences of therapists' multicultural competence suggests a moderate to strong correlation (Tao and Owen, 2015).

According to Pedersen (1999) a culture-centric perspective can be helpful in that it acts as a way of ensuring accurate assessment and clear understanding of cultural constructs. It expresses awareness and knowledge of one's own culture. It can provide the opportunity to consolidate current interventions of psychological theories by integrating the cultural context of the individual into therapeutic process. Pederson further stresses the importance of psychotherapy of a culture centered approach as if it would enhance the strength of the therapeutic relationship. Understanding between the clinician and their patients is a significant aspect when dealing mental health care. In his study Pedersen views how clinicians perceive the disease as an abnormality of the body, while the perception of the patient is mostly based on their cultural context. Therefore it is important to define and distinguish the understanding of both parties understanding regarding disease. To grasp patient's perception of their illness it is important to understand their explanatory model. Explanatory models are reference sources which guide the psychotherapy process (Klieman, 1991). Such illustrating models are used to obtain an in depth understanding of how the illness occurs, how it is interpreted, and how treatment is carried out. These models allow the process of detecting the cause of the illness to develop an effective treatment plan (Klienman, 1991). A study done by Murdock (1980) and Evans Princhard (1937) categorized explanatory models into two; those that ascribe illness to physical cause and those that ascribe it to psychosocial psycho-social issues. Understanding these explanatory models as psychological elements would help to integrate and build more effective psychotherapeutic approachs (Sodi, 2009). Studies show that clients are happier and content when their clinicians seek to use their explanatory model to understand their illness (Olwelthu, 2018).

CHAPTER THREE

Methodology

3.1 Study design

Qualitative study design was employed in this study. Qualitative study is important in developing explanation of social phenomenon. It focuses on how people or groups of people can have (somewhat) different ways of looking at reality. From qualitative study design exploratory approach is selected. This approach is important when there are very little existing investigations in the subject matter. Exploratory studies are a valuable means of understanding what is happening, and gaining new insights (Hancock, Ockleford, Windridge , 2007) .

3.2 Study setting

The study was conducted at department of psychiatry, college of health science, Addis Ababa University. The department training programs include PHD in mental health epidemiology, residency in psychiatry and clinical psychology.

3.3 Study period

The data collection was done from February to May 2020GC

3.4 Study population

The study populations were postgraduate students of department of psychiatry. The selected populations were psychiatry residents of year one (10), two (11), three (13) and first (5), and second year (7) clinical psychology trainees.

3.5 Inclusion criteria

Individuals who were graduate students of psychiatry and clinical psychology

Individuals who were willing to participate in this study

Individuals who were available during the study period

3.6 Sampling technique

The selected sampling technique was purposive sampling technique for this particular study. This technique often use in qualitative study design because it selects participants appropriate to the research questions. In this study purposive sampling was selected because the psychiatry residents and clinical psychology trainees are involved in clinical practice and encounter patients from diverse background.

3.7 Sample size

The samples were 13 graduate students; five clinical psychology trainees and eight psychiatry residents based on the above inclusion criteria. The sample size has been determined by the achievement of saturation.

3.8 Data collection

The data collection was carried out through semi structured interview which involve a number of open ended questions based on the topic areas that the researcher wants to cover. The topic guide was developed after referring several literatures which were done previously. The open ended nature of the questions posed defines the topic under investigation but provides opportunities for both interviewer and interviewee to discuss some topics in more detail. Cues and prompts have been used to probe the interviewee more on the subjects (Hancock, Ockleford, Windridge, 2007). Pilot interview was conducted in order to modify and refine the topic guide.

3.9 Data processing and analysis

This study employed thematic analysis techniques. Interviews were carried out face to face in class rooms located on 6th floor of college of health sciences building and the average time of interview was 20-30 minutes. Before the interview began the participants signed consent form. Through the process participants were allowed to ask clarification. The topic guide served as initial to begin the interview and there were probing in between to broaden the interviewees' responses. The recorded audios were transcribed (is the procedure for producing a written version of an interview) into Amharic and translated back to English verbatim after listening the recordings repeatedly. Then the transcriptions and translations were reread repeatedly to carry out the coding process which was found important by the researcher. The codes that have similar patterns and associations were grouped together. Later quest for themes takes place through combining several similar data which was coded previously. Any themes that really had not enough data support were discarded

3.10. Ethical considerations

Ethical approval was obtained from department of psychiatry, collage of health sciences, Addis Ababa University. Written consent was obtained from all participants who include the purpose of this study. In addition the participants were asked if they were willing to participate in the study or not.

CHAPTER FOUR

Result

This result was obtained from 13 participants. Among the participants five of them were second year clinical psychology trainees, 4 second year residents and 4 third year residents. Among 13 participants 5 were males and the rest 8 were females. Five themes emerged from the analysis.

4.1 Defining multicultural competence

Most of the research participants reported being unfamiliar to the name multicultural competence, but they tried to define it by common sense focusing on the term 'multicultural'. Almost all participants define multicultural competence as: the ability to understand the difference that exists between different individuals and social groups in terms of ethnicity, religion, perception about gender and it also deals with the way of communicating with patients and co-workers who came from a different background. Therefore, competence is the know-how to handle that. For example one participant defined multicultural competence as

"In my opinion multi-cultural competence means having the capability to work in various and diversified cultures and beliefs" Par4

Most of the participants emphasized being non-judgmental and being flexible or open minded when they define multicultural competence

" In my opinion, culturally competent means, let's take our country for example Ethiopia has a lot of diversified culture it is not like western countries we don't speak one language only or

have one culture only. Patients come from all around the country they came from Oromia regional state, Amhara regional state, Debub regional state or anywhere from Ethiopia therefore to have multi-cultural competence means to know what specific cultures do these community have, to provide a treatment process best suited for each culture and how we can treat these patients in their own understanding." Par 3

4.2. Perceived significance of possessing multicultural competence

Most participants reported that the multicultural competence of a professional is important for patients by creating the feeling of being understood and develop trusting this in turn leads the professionals see through their worldview.

"I believe it will affect everything starting from questioning us and the treatment, trusting us enough to share their stories, carefully follows up their treatment, taking their meds and so in my opinion our cultural competence has an effect on the overall treatment and therapy process." Par 2

Some of them said being culturally competent help us to deal with patients who have low literacy old age and for patients who came from remote area is more beneficiary

"Well this just my opinion but this people might be fixed on some thoughts they might not be very flexible. They often tend to be very rigid in their altitude and it might not be easy to make them believe otherwise. Therefore the only way we can treat this people is by trying to look through their views and believes and trying to speak their language. Same is true for people who are not well educated especially if we are explaining using pure science, I believe they might be

intimidated and wouldn't understand our explanation. They may or may not accept what we are trying to say but still it is better if we try to speak their language." Par 1

Key elements of multicultural competence

All participants said that for a mental health practitioner to be a multicultural competent practitioner he or she needs to have knowledge about their own culture and also about others culture and skill.

Knowledge

According to most participants to be a culturally competent psychiatrist or psychologist one should know or understand that there are many other different cultures other than their own. They reported to believe that clinicians need to have enough knowledge regarding the culture and beliefs of the area they are practicing in for example having a clear knowledge about different cultures in Ethiopia, that way one can easily relate and understand the patients understanding and explanation. And can easily understand the multi-ethnic terms or language in addition common religious principles and terms will positively help their communication and therapeutic process and will probably refrain from offending the patient in any way.

"*Okay as I think a psychologist must have a knowledge about the culture where his patient is from or the background of his patient let's say for example some things may be completely normal for some cultures and very odd from where we are standing so looking at the conditions from their point of view or from there angle is expected and secondly we have to be empathetic right? To help someone from different culture first of all we need to know and understand that culture as well as a general know how of their culture and social groups" Par 7*

"A culturally competent psychiatrist should at least know about culture of the country he/ she is living and culture of the patients he/ she is treating in addition if he/she try to understand the behavior and the illness from the patients perspective, that psychiatrist is competent for me" par 2

"I think me as a care giver I should understand different cultures, religious beliefs. So, if I am not that competent enough it could affect the interaction and the rapport developing process. Plus we should understand what they are saying because that is very important to them, for example, we should know what a holy water is and what do they do at the holy water place, or they relate the day they came to a saint marry memorial day, there are people who use religious events as a calendar or they might say we have read Quran on the patient, if I do not understand these situations and their believes that would be a failure I am not saying we should go deep like the religious scholars but if we know a little bit of important background then we can understand each other. Otherwise it would be difficult to help them." Par 6

Most of the participants stated that multicultural competence is not all about knowing and understanding other's culture, but self-awareness or the clinician's understanding of self, his/her cultural, religious background, perception of gender and so on are crucial while defining multicultural competence and the role it plays a great role in the treatment process starting from rapport building.

"The therapist's understanding of self or knowledge about his own cultural background is an important component while dealing with patients. Since the treatment involves interaction mostly there will be transference and counter transference so if the psychiatrist does not have self-awareness he will be new for the emotions that will be imposed on when he is talking with the

patient and this will lead to miss managing the situation. But in the case of therapy we have to contain those reactions and choose the right or professional way in helping the patient. However, if we lack self-awareness, we couldn't be able to do this in fact we will react as we please, we might even be offended some times we might suddenly understand our believe system in the middle of a session so sometimes self-awareness really matters when we come to the therapeutic process." Par 10

Attitude

All participants stated that a multiculturally competent clinician stays flexible or open minded about patient's explanatory models, avoids imposing his/her own values and beliefs that a patient's explanatory model is usually correct for the patient.

"... you know just because we are human, we ask questions we ask why we are sick and so to figure out some answers we will probably come up with some logical reasoning for psychiatric illness." Par 2

Most participants said that they accept the explanatory models of their patients and consider it as correct and use it as an input for understanding, creating and consolidating good rapport.

"It is a very accurate and right thing for them; they are just trying to justifying what happened to them. They usually are convinced this has happened to them because of some spell (curse) so I am trying to say they are right I am saying they convinced themselves. For instance, a person who suffering from Tuberculosis might come up with a valid reason he is seek by saying I may have been in contact with infected person or my immune system must have weakened. Or diabetes I may be tricky for diabetes but let's take diarrhea, we can easily these might have happened because of what I have ate before. But when you come to a condition in psychiatry

there is not enough reason for having a condition. Even there are lots things that have remained unknown in this practice that the science hasn't figured it out yet." Par 12

"Regarding psychiatry illness, that is the way we can understand the patients more, when we understand their explanatory model. But if we leave behind the cause their explanatory model and try to treat them in whole another way we might be failing. And so we need to focus on both of the (their belief system and our treatment process) by being sensitive when we have to and sometimes when they find it hard to open up it will help their explanatory model. In addition, I think lots of psychopathology might rotate around that and so it might also be very core concept." Par 7

Skill

Most of them stated that these explanatory models help them to understand the patient more and to reach to a sensible formulation and usually integrates these explanatory models with assessment and treatment plans via psychoeducation and the given therapeutic modalities.

"*…for example there is an outreach healing program held at Entoto for healing power of holy water. Since I come from same background, I know the people there might use force or even hit them (patients). Because I have the idea of this particular culture, I might understand the situation better. I will not show any kind of judgment as a professional. I will not say things like "how could they do this to him, he just has a condition, how can they not understand his illness?" because I understand where that come from, I get they mean well but at the same time we would deliver a more convenient and understanding service if we have a grasp of other religions, beliefs or cultures as a whole. Because this practice (psychiatry) have a lot to do with social science and culture so skipping this huge relationship aspect will affect the rapport. As*

you have mentioned, it will affect the clinical and treatment process too. In this regard, having knowledge of different cultures will favor the clinical process. I am saying this because I have noticed I can easily communicate with patients that came from similar background as mine." Par 1

Another important skill most participants raised is therapist's understanding of his/ her own cultural and religious biases, biases related to gender, sexual related values and so on work on the ability not to let those biases interfere in the treatment process. Possessing this skill helps the clinician to be conscious about the difference that exists between individuals in diverse society and helps to be conscious about imposing his/her own values and attitude on the clients.

"If we have some personal biases that means we are about to decide what is good for our patient but as a therapist the client should decide so if we are biased in any way, we might play the role of a decision maker. We might lead our patients in our believe direction these means we are deciding for them. This is against the discipline of psychiatry or psychology it is not allowed to lead a patient in our direction and this will result with a disagreement between the professional and the patient and patients will not benefit from this, they will get nothing from this." Par 3

"we should never let our bias to interfere in our treatment process for example let's say we do not accept homo sexuality but when a patient come to us in need of treatment that doesn't mean we should be showing any kind of judgment. As long as this person came in seek of help, we need to be professional about it. For instance, the patient may have come seeking a treatment to accept the way he/she behave sexually while alleviating his/her stress. It might not be to convincing the patient that being homosexuality is wrong and to change his attitude. In this regard we need to carefully behave as a professional" par1

4.3 Factors affecting multicultural competence

The other theme that arised was factors affecting multicultural competence the following subthemes were responses obtained from most of the participants. Exposure/experience, knowledge, personal initiation or motivation to know and attitudes are subthemes that were identified under the theme of factors that affect multicultural competence of the clinician.

Experience / Exposure

Most participants stated working with patients who came from different ethnic and religious background help the clinician to familiarize him/her with diverse background and learn from them.

"Seeing a client who has different background from me by itself can contribute because I can learn about that community from that patient. So, I learn from the people with multiple backgrounds then I will apply it to the next case that means it will not take me by surprise. And also if the therapist is open minded it will be easier to understand that cultural rituals. But if he has an exclusive attitude it could affect our judgment and rapport." Par 4

The clinician's upbringing and experience in living in a diversified environment are also contributing factors.

"If he has lived in multi-cultural Environment or if he had lived in a culturally diversified dormitory when he was undergrad or if he has those kinds of family setup, I believe he might benefit from that and he could easily understand patients." par 2

Knowledge

According to most participants for a clinician to be multiculturally competent he/she must at least know some common things about diverse population's way of living, religious principles, practices terms, etc… this helps the patient to develop trust and feeling of being understood and belongingness

"There are different religions and cultures so let's say when a patient comes seeking help he will probably come with religious, cultural and societal baggage. So, he will probably come with expectation to be treated in that way especially for the reason that mental illness often times get wronged with religious believes (evil possession and the like) patients be one of the society that believes in these cultural believes and if the psychiatrist do not take the patients believes in to consideration and if he only base his explanation on science the patient will not feel safe and will not accept the psychiatrist help." Par 2

Some participants said clinician's knowledge about their own background, values and beliefs is also another factor that affects multicultural competence.

"I think the first thing is not to know your own background or to not value your back ground will result in being inconsiderate to others attitude and culture. And I think knowing our background and understanding others is a good factor. There was no personal challenge I have faced due to this" par 9

Personal initiation and motivation to know

Almost all participants agreed on the clinician's motivation and determination to explore more about different cultural backgrounds using social medias, movies, documentaries, reading books,

spending time with people who came from different background and speaking with different religious leaders.

"If the therapist is curious to know about multicultural issues now is the favorable time given the availability of different materials through social medias, documentaries and books" Par 11

Attitude and personal bias

Some participants said knowing about our own values, beliefs and personal biases play a great role in dealing with diverse patients. Being open minded, non-judgmental and the willingness to learn from clients and listening to what they are saying without trying to impose the clinicians' beliefs also gives the chance to go deep to the patient's own world view.

"If the therapist is occupied with his own ideas and beliefs while seating in the help provider' chair it could affect the treatment process and out come because even the psychoeducation he is going to provide is all about his own values which is greatly influenced by the deep values he held about a certain things" par 8

"I think the first thing is as you have asked me not to know your own background or to not value your back ground will result in being inconsiderate to others attitude and culture. And I think knowing our background and understanding others is a good factor. There was no personal challenge I have faced due to this." Par 9

4.4 Barriers to being multicultural competent practitioner

The fourth theme emerged from the analysis was barriers to being multicultural competent practitioner. All participants raised that various barriers can interfere in their practice while working with diverse population. Lack of the practitioner motivation, Personal biases or attitude,

Lack of knowledge, Language barrier, Lack of Exposure/Experience were the subthemes identified.

Lack of the practitioner motivation

All most all participants reported that the root of all barriers which interferes between the practitioner and his/her multicultural competence is lack of personal effort or motivation to explore further about different cultures, religions, way of living, understanding of an illness and so on

"I think the major problem arises from the professional lack of initiatives I think if one has an initiative, he/she can be culturally competent. I don't think so, not in this time (generation). If you have motivation you can know more, we have internet, our community by itself is much diversified so we just need some exposure. So, if you want to make ourselves competent, you can." Par 3

Personal biases or attitude

Most of them reported practitioners fixed beliefs, closed mindedness and being judgmental affects the practitioner's multicultural competence and greatly contributed to weak rapport between the two parties.

"*The therapist's personal principles could play a role. Like I said even though you are not religiously, ethnically, politically open minded and if we don't have a welcoming attitude and if we reject, if you are standing at a corner, you can see through other person's perspective." Par 5*

"There are cultures in Ethiopia that I don't know about, but if I am specified with my own culture and if I can't be as open as I should be to listen and understand, I could be wrong. So I think it's important to understand" par 4

Lack of knowledge

Most participants said that failure to have knowledge about diverse society while living in a diversified society made the treatment process difficult

"Well I wish to have deep knowledge about different things. For instance, about different cultures, about politics etc. it is required from psychologist to have a diversified knowledge. Let's say for example an athlete has come to you in need of help if you know something fascinating about athletics you are more likely to develop a rapport quickly. So in general it is essential for professionals to improve our reading skill and try to have an all rounded knowledge." Par 3

Language barrier

Some participants mentioned language as one problem while engaging with people who came from different regions of Ethiopia. If clinicians were multi-linguistically competent, they could work well with linguistically diverse populations. In Ethiopia, ideally, they need to know at least common languages who have many speakers and this could be asking too much.

"Ethiopia has several ethnicity and most of them have their own language. Learning all of these languages is not feasible and dealing with those patients made the treatment process difficult, even though there is translator he may not convey the exact feeling of the patient and he may edit the patient's exact word." Par 8

Lack of exposure/ experience

Most participants said lack of exposure or experience in working with diversified or multicultural clients affects the practitioner's multicultural competence

"I think we don't have enough exposure from all of the cultures in Ethiopia. Patients come from various places and money of the professionals are practicing in Addis Ababa and I believe not having these exposures will negatively affect my practice as a culturally competent person. For instance, I had no recollection that some people burn their own skin and I have learnt this culture very late. For this reason, if we had no idea people do this in thought of keeping illness away one may contemplate this person is struggling with self-injury or self-implicit. Accordingly, since we have a much diversified culture, we need to read more, dig more and having interest to know more is required." Par 11

Chapter Five

Discussion

This particular study has explored the overall understanding of practitioner's who are graduate students of psychiatry and clinical psychology at college of health sciences, department of psychiatry, Addis Ababa University.

All participants defined multicultural competence as the professionals' ability to identify differences in terms of ethnicity, religion, gender, sexual orientation and to work with this diversified environment. This definition is consistent with other definitions given by scholars (Wilson, Ward and Fischer 2013).

While theoreticians have advanced philosophical writings and empirical work concerning multicultural counseling issues experts in the multicultural counseling arena still have to agree on the particular variables that should be used when defining the word 'multicultural'. Researchers who favor a definition that would include broad variables, such as race, ethnicity, social class, gender, sexual orientation (e.g., Fukuyama, 1990; Pedersen, 1988; Speight et al., 1991) argue that all counseling is to some extent multicultural and that counselors require training to enable them to bridge cultural gaps between themselves and their clients (e.g., Sue et al., 1982; Vontress, 1988). Others argue that an inclusive definition leads to the critical variables of race and ethnicity (Helms, 1994) and the term 'multicultural' becomes meaningless because it denotes nothing beyond individual differences (Locke, 1990), while definitional challenges are inherent in dealing with such a complex term, it is essential for multicultural researchers to continue the process of exploration and dialogue to a better understanding of the issue.

The clinicians reported a multicultural competent professionals actively work towards increasing their understanding of their client's cultural context and world view; creating and using culturally responsive client specific approaches and treatment strategies; and raising awareness about their own perceptions, attitudes and values and also how they can influence interactions with a client which can go hand in hand with the study done by Sue et al, 1992.

Most participants stated that multicultural competent practitioners need to have knowledge about the client's background, values, explanatory models of an illness, world view. More over multicultural competency became all rounded when the professional have self-awareness about his/her own world view, values, religious background, and personal bias and so on……

Most participants reported that the key elements of multicultural competence are knowledge about patients/clients ethnic and religious background, how illness and wellness is perceived and explained from their point of view. Participants typically believed that possessing multicultural competence included having knowledge and awareness of cultural issues. Multicultural competent practitioners had knowledge and awareness of the impact of demographic/cultural variables in peoples' lives. Participants occasionally noted that multiculturally competent professionals had general knowledge and awareness about cultural issues and historical variables. This notion is consistent with the study done by Constantine in 2004. He asserted multicultural counseling involves knowledge about common cultural issues , situations related with clients upbringing and clients psychological well-being.

In line with knowledge participants typically believed that self-awareness is also important aspect of multicultural competence and practitioners, self-awareness and understanding personal bias greatly influence the treatment process and outcome. Participants reported that a

multiculturally competent professional knows about their own cultural, ethnic, religious background, values and beliefs. There needed to be self-awareness of one's cultural identities. A major step in becoming multiculturally competent was to be aware of oneself as a racial, cultural, ethnic, gendered being; part of multicultural competence is the ability to recognize and acknowledge one's own privileged group statuses. Some participants stated that people needed to be aware of their biases/ stereotypes/ judgments/ limitations. Practitioners should possess awareness of their own value systems Constantine et al., 2004 argued that counselors should recognize the fact that they have been largely indoctrinated to ascribing negative labels to certain groups of people. Participants also reported multicultural competence included being open-minded, flexible, and willingness to learn from multicultural patients which contributed to positive treatment outcome and process.

Additional element of multicultural competence is the skill related to listening and accepting patients' explanatory models and integrating those explanatory models in assessment and treatment plan. A study done by Constantine and colleagues in 2004 noted that multiculturally competent counselors possessed specific skills. The first specific skill is the ability to make culturally sensitive therapeutic interventions (e.g., specific skills are needed in terms of listening to, assessing, and conceptualizing clients' concerns from multiple worldviews); the second skill the ability to integrate counselor and client cultural identities into the therapy process and relationship. Counselors need to understand issues of power both generally and specifically with regard to the therapeutic relationship, and they should use of this awareness to counsel clients effectively and sensitively); and the third skill putted by them is the ability to integrate diagnostic and cultural factors into multicultural case conceptualizations for example when dealing with

issues such as depression, counselors should understand these issues within the whole context of the person's life, and not just within the context of diagnostic categories.

Participants mentioned several factors that can affect multicultural competency such as prior experience or exposure of professionals in working with diverse society. This factor is consistent with Constantine et al (2004) study which asserts broad and diverse life experiences that the counselor has emerged as an aspect of multicultural counseling competence was the counselor has. A lot of multicultural counseling competence comes from life experiences (i.e., the broader the life experiences, the more potential counselors had to quickly develop multicultural competence). Another factors that affect multicultural competence are personal characteristics of the practitioner such as initiation or motivation to know and broaden his/her knowledge through reading books, published researches and articles, watching movies, documentaries done about cultures, religions, traveling to places, having small talks with people who came from diverse background.

Regarding obstacles of being a multicultural competent practitioner is language barrier. Some participants reported that language difference between the clinician and the patient made the treatment process and treatment outcome difficult because it hinders the real and original presentations of patients' complaints even though there are translators. There is a similar finding in a study done on Malaysian psychologists who engage in treatment with clients who are Malay-Muslims and non-Malay Muslims (Jaladin, 2013). Participants claimed their lack of exposure or experience in treating multicultural patients is another obstacle that affects their multicultural competence since they work only here in Addis Ababa. The Malaysian study also stated similar barrier (Jaladin, 2013).

More over participants point out another barrier of multicultural competency which is professionals' value conflicts or attitudes. Participants reported experiencing conflicting personal and professional values and conflicting cultural values between them and their clients. Due to these, the treatment process and outcome might be affected as a result of problems such as unfinished business, countertransference, frustrations and learned helplessness in their practice. This finding is consistent with Jaladin's research done in Malaysia in 2013.

Conclusion

The findings from this study give insight on the perspective of graduate students of psychiatry and clinical psychology; how they define multiculturalism, factors that affect multicultural competence are personal characteristics such as the motivation of practitioners to know more about multicultural competence, knowledge regarding cultural identities of diversified society, beliefs and attitude they have towards other culture and their own background, prior experience or exposure in working with multicultural population, etc. this study has explored on clinicians perceived challenge and barriers from being multiculturally competent practitioner; these are lack of knowledge about self-cultural background and others cultural background, personal biases and attitude such as being judgmental , closed mindedness and lack of experience

Limitation

The research study only focuses on graduate students of psychiatry residents and clinical psychology trainee as a result the sample is not representative of practitioners who are engaged in treatment with multicultural patients and the result could not be generalized. Another limitation of this study could be social desirability of response bias because the interviews were conducted by a clinical psychology trainee of psychiatry department, Addis Ababa University.

Recommendation

Further study in this area is essential since different literatures including this study found the concept of multicultural competence is key issue in treating patients who came from different background. Most of the researches are done by western scholars and since we are speaking about multicultural competence indigenous studies should be encouraged to strengthen and improve professional mental health care.

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Appendix 1

Informed consent

I am Hawi Shigut, a post graduate student at Addis Ababa University**,** Department of psychiatry. Currently I am doing a qualitative research on perception of multicultural competence among graduate students of psychiatry and clinical psychology in the department of psychiatry, Addis Ababa University. This study is part of the requirements for Masters of Sciences in Clinical Psychology.

The aim of this study is to explore the understanding of psychiatry residents and clinical psychologists about multicultural competence since they encounter many individuals from different cultural groups.

The reason I chose you as this study participant is because you I believe you have much experience in working with patients who are diverse in terms of ethnicity, gender, religious background and various social groups. You will be asked some questions regarding your overall perception about multicultural competence, factors that affect cultural competence, barriers to be culturally competent practitioner.

You will be asked to participate in an interview that is estimated to take maximum one hour. If you agree to this interview, all the information you will give remain confidential and anonymous in addition the information collected from you will be coded using numbers. If you don't want to answer a question or stop the interview, you can withdraw from participation at any given moment in the interview. Participation in the study will not yield any material benefit to the researcher and the participant.

Signature

Appendix 2

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ያሉበት የትምህርት አመት

1. Multicultural competence ማለት ላንተ/ላንቺ ምን ማለት ነው？
2. አንድ ሳይካትሪስት/ሳይኮሎጂስት culturally competent ነው የሚባለው ምን ምን ነገሮችን ሲያሟላ ይመስልሀል/ሻል？
3. ታካሚዎችህ/ሽ የመጡበት background ተግባቦታችሁ ላይ እንዴት ተጽእኖ የሚያሳድርይመስልሀል/ሻል？ታካሚው የመጣበት ሃይማኖት፣ ባህል፣ ብሄር፣ ማህበረሰብ የሚኖራችሁ rapport ላይ ምን አይነት ተጽእኖ ይኖረዋል ብለህ/ሽ ታስባልህ/ታስቢያልሽ？
4. በልምድ ካየኻው/ሽው በባለሙያው ስለራስ ማወቅ እና በህክምና አሰጣጥ ሂደት እና ውጤት መካከል ግንኙነት አለ ብለህ/ሽ ታስባለህ？
5. የራስህን/ሽን የባህል፣ የሃይማኖት፣ የጾታ አመለካከት ጉድለቶች ማወቅ የተለያየ background ያላቸውን ታካሚዎችን ለማከም ጠቃሚ ነው ብለህ/ሽ ታስባለህ/ሽ？እንዴት？
6. በሰራህባቸው/ሽባቸው ጊዜያት ካየኻው/ሽው ለምን አይነት ታካሚዎች ነው cultural competence ተመራጭ ሚሆነው？ ለምን？
7. ታካሚዎች ስለ ህመማቸው ስላላቸው explanatory model ምን ታስባለህ/ሽ？
   a. በብዛት ምን አይነት explanatory model ይጠቀማሉ？ምን ያክል ልክ ናቸው？
8. የታካሚዎችን explanatory model በ assessment እና በ treatment plan ላይእንዴት አርገህ/ሽ ለማቀናጀት ትሞክራለህ/ሽ？
9. በስራ ልምድ ካየኻው/ሽው ምን ባለሙያው cultural competence ላይ በጥሩም ሊሆን ይችላል በመጥፎ ሁኔታ ተጽእኖ የሚያሳድሩ ነገሮች ምንድን ናቸው？
10. Culturally competent ባለሙያ እንዳትሆን/ኚ ምን ምን ተግዳሮቶች ሊኖሩ ይችላሉ ብለህ/ሽ ታስባለህ/ሽ？
11. በግልህ/ሽ multicultural competenceህን/ሽን ለማሻሻል ምን ማድረግ አለብኝ ብለህ/ሽ ታስባለህ/ሽ？በዲፓርትመንት ደረጃስ？

Appendix 3

Topic guide

Demographic questions

Gender

Academic year

1. How do you explain multi multicultural competence?
2. How does patient's background affect your communication with them? How does patient's social, subcultural, ethnic, racial or religious background affect your rapport?
3. In your experience, is there any relationship between self-awareness of the therapist and the treatment process and outcome?
4. How does understanding your own subculture, religion and perception of gender biases have anything to do with treating clients from different backgrounds?
5. Based on your experience, for what type of patient is cultural competence most important? Why?
6. What are your views of traditional explanatory models of an illness?
    a. Probe for knowledge and attitudes as well as attitudes towards clients who hold traditional explanatory models of illness
7. How do you work with the above situation?
    a. Probe for how the participant incorporates the clients traditional explanatory models into the assessment of the presenting problem
    b. Probe for how he/she incorporates traditional explanatory models into the treatment plan
8. In your experience what factors do you think affect cultural competence?
9. What are the challenges to being a culturally competent practitioner?
10. In your opinion what measures should be taken to improve therapist's multicultural competence?
    a. Personally as a mental health professional
    b. In department level