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Teaching Not-Knowing: Strategies for Cultural Competence in Psychotherapy Supervision

Priya Watson[1] · **Priya Raju**[1] · **Sophie Soklaridis**[1]

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Effective psychotherapy requires a culturally competent clinician. Cultural competence is broadly understood as the ability to work skillfully across cultures, engaging the perspectives and identities of both clinician and patient [1]. The concept has been moving from the margins to mainstream of psychiatric pedagogy [2, 3]. While cultural competence is increasingly seen as a core component of training, it remains challenging to operationalize. Arguably, all psychotherapy is cross-cultural, as even a clinician and a patient from similar sociodemographic backgrounds may have widely differing constructs of mental health, relationships, and indeed of the psychotherapeutic process itself. Clinicians must skillfully navigate these complex cultural issues to achieve the alliance, attunement and collaboration necessary for a positive treatment response [4]. The complexity deepens as trainees, patients, and supervisors bring many different cultural systems into play when engaged with one another in therapeutic and educational experiences. A culturally competent supervisor must provide teaching strategies to help the trainee navigate these intersecting cultural forces.

Two approaches to cultural competence dominate the literature, each of which fall short in helping supervisors develop these teaching strategies. In the first approach, rigorous and structured instruments, such as the DSM-V Cultural Formulation Interview or the previous Outline for Cultural Formulation, offer concrete tools but have incurred critiques for being rigid or formulaic when culture is inherently fluid and evolving [5]. In the second approach, theoretical writings on cultural competence present thoughtful critiques of mainstream paradigms and assumptions but offer few strategies for embodying these insights in specific educational techniques. Supervisors are thus left with the predicament of needing to teach their trainees to navigate issues of culture without a clear sense of just how to do so [6, 7]. The great challenge of teaching cultural competence is to reconcile the gap between pre-written algorithmic approaches and the clinical positions of openness, curiosity and uncertainty that are the hallmarks of a culturally competent practice.

This paper offers a set of supervision strategies that bridge the gap between prescriptive clinical instruments and more theoretical discourses on culture. We have distilled these strategies from a focused review of the education, culture, and psychotherapy literatures to devise a theoretical approach and skill set that educators can implement into practice. We have named our model for teaching cultural competence the "not-knowing stance". Readers familiar with Mentalization-Based Therapy will recognize Bateman's description of "not-knowing" as one part of a therapist's position [8, 9]. This paper draws from this and other literatures to expand the term "not-knowing," defining and operationalizing a core stance required in cross-cultural clinical and teaching spaces. We delineate three primary teaching components of the not-knowing stance: *reflection*, *humility*, and *working with otherness*. In the not-knowing stance, each of these strategies is engaged simultaneously and each strategy promotes the other.

Although these techniques have broad application across psychiatric education, here we embed the not-knowing stance within the process of psychotherapy supervision. This addresses the complex supervision and clinical challenges that arise over time, whereas most of the cultural competence literature focuses primarily on assessment. At the end of the paper, a case example illustrates the not-knowing stance and

✉ Priya Watson
priya.watson@camh.ca

[1] University of Toronto, Toronto, ON, Canada

specific techniques for teaching cultural competence are detailed.

A Brief History of Cultural Competence

"Cultural competence" in psychiatric education is a relatively recent construct. Academic publications on the subject began appearing in the 1950s, the sub-discipline was recognized by the APA in the 1960s, and several international organizations were created over the 1970s and 1980s to advance the field of study [10]. One social context for this process included the civil rights and other anti-discrimination movements in the USA, which led to regulations promoting equity in various domains [ibid]. Cultural competence came to be described as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" [1]. The term has since gained popularity in multiple domains, including government and non-profit sectors, and has been increasingly prominent in health care literature [11].

The meanings of "culture" have also evolved over time, with implications for how cultural competence is conceptualized and taught [12]. Early anthropological definitions of culture ascribed relatively static traits to discrete groups, while more post-modern interpretations define culture as a dynamic, transactional, and even political process by which individuals and groups negotiate identity [13]. Similarly, contemporary ways of understanding cultural competence range from "content" approaches, which address the needs of specific ethnocultural groups, to "process" approaches, which examine power and identity dynamics between patient, clinician, and the social systems that surround them [14]. Critics note that the term "culture," when used as solely as a proxy for race or ethnicity, risks masking disparities that are actually social, economic, or political in nature [15].

In the content-oriented approach to cultural competence, which has dominated the literature, the clinician learns the cultural norms of the patient's self-identified sociocultural group [16]. Here, information is power, helping a clinician to anticipate her patient's cultural meaning systems and adapt her practice accordingly. One common example of the content-oriented approach is to provide "like-ethnic" therapists for patients and assume that issues of culture are thus effectively addressed [ibid]. The content-oriented approach has significant limitations. It is reductionistic, presuming that ethnicity, language or country of origin are suitable proxies for culture. Patients are thus ascribed traits or perspectives based on untested assumptions about their identity [17, 18]. Further, if cultural competence relies upon acquiring a new set of culturally appropriate information, the clinician may opt out entirely. This treatment avoidance may be particularly likely when it comes to psychotherapy, with its ongoing complexities and ambiguities. Thus, a content-oriented model of cultural competence may paradoxically engender a sense of "incompetence" in clinicians [19, 20].

The process-oriented approach to cultural competence focuses on how "clinicians ascribe meaning and integrate such meaning in the clinical encounter rather than what therapists know about specific groups" [16]. This approach is skills-based; rather than relying upon static ethnographic knowledge, it emphasizes attending to identity-based negotiations, including issues of power and perception [21]. This approach is iterative, evolving, and flexible, much like culture itself [22]. Process-oriented approaches may also better support research and evaluation initiatives, because they can be more readily taught, measured, and then tested [6]. This is an important strength, as process and outcomes research in cross-cultural psychotherapy is sorely lacking [4]. However, the fluidity of this approach may also be a limitation. Its lack of specific directives may frustrate clinicians seeking clinical skills and offers minimal guidance for supervisors to devise reliable and effective teaching methods [5, 14, 22].

Many culturally competent supervisors integrate both content and process-oriented approaches in their own psychotherapy practices by moving between specific knowledge of cultural norms and flexible critiques of that knowledge. Without clear direction on how to teach the integration of these approaches, however, supervisors may struggle to communicate this competence to their trainees.

The Not-Knowing Stance

Reflection

The first element of the not-knowing stance in culturally competent supervision is reflection. Engaging in reflective practice is a way for supervisors to teach trainees how to flexibly move from untested assumptions to new perspectives, and how to maintain self-awareness through the cognitive process. This type of meta-cognition (thinking about one's thinking) and self-awareness is essential to the not-knowing stance of cultural competence. Culturally competent reflection engages with multiple meaning systems—the cultures of patient, trainee, supervisor, and the practice of psychotherapy itself—and does so explicitly [23]. Reflection "involves cultivating habits of mind such as experiencing information as novel, thinking of 'facts' as conditional, seeing situations from multiple perspectives, suspending categorization and judgment, and engaging in self-questioning" [24]. Like supervision, reflection also has as its explicit goal a change in outcome, an increase in skill or technique, and an active revisiting of unexamined habits. Thus, reflective practice is essential to the dynamic process-based approach to teaching cultural competence.

Donald Schon's influential work on reflective practice described two forms: reflection *in* action and reflection *on* action [25]. Both are required when teaching cultural competence. In the "parallel process" of supervision, engaging with a supervisor in reflection on the psychotherapy session fosters the trainee's ability to reflect in the next meeting with the patient. Reflection *in* action refers to the cognitive flexibility and sensitivity that allows a therapist to navigate cultural issues in a psychotherapy session. A trainee can learn these skills if they are modeled consistently by a supervisor who engages in active questioning, revisiting hypotheses, and encouraging uncertainty.

Trainees can be "enculturated" by their supervisors [26] either to minimize their uncertainties and questions or to consider and explore these uncertainties through reflection. Unfortunately the former is generally the norm, as uncertainty (often perceived as incompetence) is given short shrift in medical training [27]. This is apparent in the format of supervision itself, wherein a trainee presents a retrospective narrative of the psychotherapy session for the supervisor to digest and evaluate. Trainees are vulnerable to the idea that they should project certainty and coherence in these narratives, and in their formulations and treatment plans, without leaving room for the ambiguities, dissonances, and uncertainties of the experience. Beyond these pressures to project certainty, there is also a legitimate developmental need, particularly for early stage trainees, to feel that they are acquiring reliable and usable skills and knowledge. Supervisors are no less vulnerable to this process [28]. As the supervision draws to an end, which is often due to external artifacts such as the end of a rotation or a particular number of sessions, there is pressure on both supervisor and trainee to create a narrative explanation of the patient that also confers a sense of closure.

When multiple levels of meaning and multiple forms of cultural enactment are taking place, the clinical narrative must perforce be unstable and uncertain [21]. Forcing a sense of stability and coherence on this narrative might allow for reduction in uncertainty and professional anxiety. But then supervisors lose a central opportunity that working across culture provides: the opportunity to work with not-knowing, modeling for learners how to allow for multiple levels of meaning, story, and practice to emerge [29–31].

Humility

The construct of humility in cultural competence can be a provocative one. Kirmayer notes that cultural humility is "a willingness and ability to listen and learn from patients," which must be done "without shying away from the way in which culture and difference are used to stereotype and oppress people or divert attention from various forms of structural violence" [12]. Structural violence refers to the failure of social institutions to meet the basic needs of marginalized groups [32]; it is a systematic level of oppression. To engage explicitly with this oppression can be new and daunting territory for both trainee and supervisor. Nonetheless, through cultural humility, both the supervisor and trainee are prompted to address the social realities of the patient and to examine the ways in which power imbalances may be enacted within the psychotherapeutic encounter itself. Cultural humility builds cultural competence by promoting ongoing self-evaluation, engaging with power imbalances, and fostering a collaborative approach to treatment [33]. Humility also facilitates reflection. Humility allows a therapist to hold her own and her patient's positions simultaneously, and to release unhelpful assumptions more quickly. The flexible thinking of culturally competent reflection thus requires cultural humility.

Cultural humility promotes deep cultural reflection because it provides an opportunity to explore fundamental uncertainties, even questioning the paradigm of psychotherapy itself [34]. With humility, psychotherapy itself is understood as one option within a range of possible healing practices. This stance challenges typical process for teaching psychotherapy, in which supervisors reflect early with trainees on the patient's "suitability" for psychotherapy. This reflection focuses on the patient's readiness, or commitment level, or psychological-mindedness. In so doing, however, supervisors perpetuate a notion of the universality of psychotherapy, locating the lack of suitability within the patient, rather than the treatment. The pedagogical challenge for supervisors of culturally competent psychotherapy is to expand these reflective practices and acceptance of clinical uncertainty to include the notion that psychotherapy, as a particular cultural practice, may not fit the suffering experienced by a patient [35].

Working with Otherness

The final element of cultural competence is working with otherness. For each person in an encounter, there are unknown and likely unknowable aspects of the other person. When therapist and patient collaboratively acknowledge and explore the "inescapable otherness of a clinical encounter" [21], even if the process has no particular resolution, the discussion of the predicament can itself promote understanding and alliance. They have jointly explored what they know and explicitly examined where their cultural perspectives diverge. Working with otherness requires reflection, which is the process by which these uncertainties are uncovered, as well as humility, which enables the trainee to appreciate the limits to her personal experience and understanding.

The cross-cultural clinical space has been described as containing a "multiplicity of voices which are a constant source of critique and disequilibrium" [36]. This disequilibrium can be very difficult for trainees to tolerate and can lead to treatment avoidance or alienation from the patient. An anxious perception of difference, or assumption that certain aspects of the patient render her alien to the therapist, can occur in the

therapy process. When this perception of difference is essentializing and marginalizing, it has been termed "othering." Othering occurs when an individual or group is ascribed traits that are experienced as foreign, undesirable, or alienating. This can occur both systemically and interpersonally [37]. Working with otherness means validating and exploring difference without retreating into alienation or therapeutic helplessness and thus is the antithesis of othering.

Skillfully working with otherness is all the more vital given the highly pluralistic societies in which we live. Western cultures, including the culture of psychiatric training, typically conceive of the self as a bounded entity operating through an individual mind [38]. Psychotherapy supervisors must nonetheless prepare trainees for engaging with patients who may have self-concepts that are not bounded or individual but could be instead inextricably linked with community (socio-centric), the natural world (eco-centric), or the world of spirit (cosmo-centric) [39]. There are many other areas of possible divergence between patient and therapist, including lines of class, education, sexuality, and other sociocultural lived experiences [40]. The true otherness of a patient and her suffering pose an existential challenge to the uses of psychotherapy, particularly if left unexplored [4, 41, 42].

Teaching cultural competence in psychotherapy is a complex task. Clinical spaces contain a central tension between sameness and otherness, between that which can be understood and that which may be too far outside the frame of reference of the therapist or the Western discipline of psychotherapy to be comprehended within it. The role of the culturally competent supervisor is to promote the recognition and exploration of these uncomfortable tensions, and to validate the experience of not-knowing [43–45]. This requires an iterative parallel process of reflection, the use of humility to appreciate issues of power and the limits of our assumptions, and a mutual exploration of otherness.

Case

The following composite case offers examples of teaching cultural competence within psychotherapy supervision. The dialog between psychiatry resident and supervisor is written to demonstrate applications of the strategies of reflection, humility, and working with otherness.

Dr. Ng is a mid-career academic psychiatrist who has just begun supervising Theresa, a resident, in psychotherapy. The patient Susan is a 20-year-old woman from a small-town, lower-middle class family of multigenerational English/Irish background. She has been depressed for 2 years, since she moved to the city for university. Starting in her first year of university, she also began having casual sexual encounters with various male friends. She tells Theresa guardedly that she enjoys these encounters and seeks them out, adding that many of her sorority sisters do the same.

Theresa confesses to Dr. Ng that she is not sure what to make of Susan's sex life. She herself grew up in a conservative professional East Indian family and these choices are unfamiliar to her. She notes that they represent a departure from Susan's previous pattern, which correlates with the onset of her depression. She asks somewhat awkwardly how she should include this sexual activity in her formulation of Susan's depression.

Dr. Ng: So you're trying to figure out if this is a depressive symptom.

Theresa: Exactly. But I'm not sure if I should discuss it with her… especially if that's just how she and her friends operate. I don't want to pathologize this just because it wasn't a part of my reality in university.

Dr. Ng: That's worth exploring – you're wondering about her different "way of operating". When you say that these choices might be "how she operates", and not part of your "reality", what are you referring to?

Theresa: Well, sex is more casual in this generation. And she comes from a different background from me – I mean, I'm not strict about this stuff like my family is, but I just wasn't around people making these kinds of choices.

Dr. Ng: So Susan feels fundamentally different from you – like an "other". Sometimes we get that feeling when dealing with issues of "culture", meaning whole systems of norms, comforts and discomforts, behaviors, and so on. First let's name the specific cultural differences we're talking about here. You said part of why you get a sense of "otherness" about Susan is because of generation. And also because of her "background". Can you clarify that one?

Theresa: Well, I guess maybe economic class background? Or me being from an Indian or immigrant family or something, and her being a White Canadian. I do wonder if my questions about this sexual stuff could just be about our different backgrounds.

Dr. Ng: I can see that you want to be really careful about this, especially because of your sense of cultural difference from Susan. How might you deal with this as a cultural issue in psychotherapy?

Theresa: (hesitant) Well, I actually do support people making their own sexual choices, free from the judgment of others. So if this is Susan's "cultural" way of being at this point in her life, then I don't want her to

think that I see it as a problem. But, if it's not a cultural issue, she could be compulsively seeking the comfort of others, or struggling to fit in.

Dr. Ng: Rather than framing this as just Susan's cultural issue, let's think of it as a cultural issue between the two of you. Culture isn't just a characteristic of one person; it shows up in dynamics between people. How do you think this has affected choices you're making in your sessions?

Theresa: Well… when she starts casually talking about sex, I ask a few questions about her experience, and then move on from the topic. I haven't said much about it yet.

Dr. Ng: Is this sense of Susan's "otherness" kind of paralyzing for you in the session?

Theresa: I hadn't thought of it that way, but yes, I feel like I flounder every time we talk about her sex life.

Dr. Ng: Sounds like that's a tension you will have to keep holding with her. Operating within uncertainty is its own skill in psychotherapy, especially when culture seems to be a major factor. I wonder, could this be both "depressive symptom" and part of a cultural reality that differs from yours? We may never fully know – and that balance could shift with time.

Theresa: I'm not sure what to do about that.

Dr. Ng: That's understandable – and it's okay not to know. We can hold this uncertainty through reflecting together in supervision. We'll keep naming our questions, missteps, new rounds of questions, and so on. We can also be transparent about this process with our patients. Is this something you've considered talking about with Susan?

Theresa: You mean telling her about my questions about what all this casual sex means?

Dr. Ng: Yes. Letting her in on your uncertainty and even your wish not to seem judgmental. That may help you to be less "stuck" when this topic comes up.

Theresa: I worry it'll make me seem like I'm fumbling more, or that I don't understand her.

Dr. Ng: Not understanding your patient fully is inevitable. Finding a way to discuss that is an essential part of cultural competence. Otherwise you end up holding on to assumptions, or avoiding topics altogether. Just the process of collaborative reflection allows for a better understanding and a better alliance. Keep noticing how you're approaching this with her, and we'll keep talking about it here.

Theresa: Okay – I'll pay more attention to my choices next time. I can even try sharing some of my questions with her when they come up.

Dr. Ng: I think that's the key, even if you don't go into details about the cultural differences you see. That is how you work with that sense of "otherness" – by acknowledging the fact that you and Susan, like any two people, may not fully understand each other in several ways, although in other ways you might. This is generally part of good psychotherapy, but it's particularly important as a part of your stance on culture. How do you think Susan's sense of your difference could be affecting the sessions?

Theresa: You mean me being an "other" to her?

Dr. Ng: Yes. How might you be striking her, or impacting her presentation of herself?

Theresa: Hmmm. I wonder how she sees my age. I also find that people can get weird racist ideas about Indian women and sexuality… so I'll pay attention to that possible dynamic. I bet I come across as conservative in terms of how I dress and act, so maybe she's ashamed, or holding back the full details.

Dr. Ng: All good questions to start with. And what about your relative positions in the room, in terms of power? You're the doctor, right?

Theresa: That could be affecting her too.

Dr. Ng: Any ideas how?

Theresa: I'm sure she generally wants my good opinion, which would highlight shame. Also, now that you mention power… she may need for me to stick to a "symptom" angle, because I know she needs a medical letter for school. I hadn't thought of that part.

Dr. Ng: Right. This is definitely another challenging part of the work, because our positions of power in the therapy situation do affect the dynamic.

Theresa: (worried) I'll have to think more about how to treat all these issues. She's dealing with lots of things, like her life transition, new responsibilities, relationship choices, and so on.

Dr. Ng: Do you think Susan's looking to address all of that through psychotherapy?

Theresa: Aren't those are all aims of treatment? To help her individuate, and take on adult roles?

Dr. Ng: I know that can be how we expect treatment to look in our professional "culture". Yet it's vital to align with what Susan sees as her problems and possible solutions. She may be looking to resolve particular symptoms only, in which case her other issues and choices don't necessarily need more psychotherapy. In her worldview, exploring different activities and connections may be the way to achieve those goals. Perhaps our particular cultural explanations and solutions like psychotherapy may not be fully relevant for Susan. This kind of humility about what we're offering, and how appropriate it is, helps to connect with our patients in a more culturally competent way, because we're less likely to miss their values and expectations.

Theresa: That hadn't even occurred to me, but it makes sense – I've met lots of patients who don't see psychotherapy as solutions for them, even when I think they need it.

Dr. Ng: Well, you could both be right in different ways! The point is to keep reflecting actively on the multiple options and cultural perspectives, and to do it collaboratively with both your patients and your supervisors! What is it like for you to discuss your concern about this whole sexual topic in supervision, with me?

Theresa: (surprised) Fine, I guess.

Dr. Ng: It's always worth exploring how you and your patient are reading each other, and the same is true for you and your supervisor. I noticed that you indicated that you were raised more conservatively than Susan, but then specified that you had more liberal values than your upbringing.

Theresa: …Well, I guess it's hard to know what a supervisor might think about these things. And if I specifically mention being from an immigrant family, I don't want you to think that that dominates my thinking either.

Dr. Ng: That makes a lot of sense to me. Uncertainties about how we're being perceived run through all of our interactions. The main point is for each of us to explore how these issues are framed between us. You and I are also negotiating different cultures and systems of meaning, our perceptions of "otherness", the power relationships between us, and so on. So here in supervision we'll be drawing on those same skills I've described to you in your ongoing work with Susan.

In this supervision session, Dr. Ng holds a culturally competent not-knowing stance with Theresa using the interconnected techniques of reflection, humility and working with otherness. Through active questioning, Dr. Ng raises hypotheses about Theresa's work with her patient, and in parallel, about their process in supervision. This collaborative reflection explicitly fosters uncertainty throughout. This reflection requires humility of Dr. Ng, who questions the role of power imbalances, and invites Theresa to consider the possible limitations of the psychotherapy itself. Dr. Ng questions Theresa about the role of "difference", both in her clinical work and in the supervision. Dr. Ng helps Theresa to begin working with otherness by engaging with Theresa's perception of difference and inviting her to think critically about the sociocultural contexts that might give rise to it. Working with otherness and the uncertainty it invokes is further promoted with Dr. Ng's acknowledgement of the "unknowable" aspects of clinical work.

The not-knowing stance of cultural competence, with its embedded strategies of reflection, humility, and working with otherness, bridges the current literatures on cultural competence, psychotherapy, and psychiatric education. It offers supervisors specific techniques for guiding trainees through complex clinical encounters, while attending carefully to the interpersonal and systemic social factors by which culture manifests itself in the practice and teaching of psychotherapy.

Compliance with Ethical Standards

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

References

1. Cross T, Bazron B, Dennis K, Isaacs M. Towards a culturally competent system of care, vol. I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center; 1989.
2. Lim RF, Lu FG. Culture and psychiatric education. Acad Psychiatry. 2008;32:269–71.
3. Kirmayer LJ, Rousseau C, Guzder J, Jarvis GE. Training clinicians in cultural psychiatry: a Canadian perspective. Acad Psychiatry. 2008;32:313–9.
4. Lo HT, Fung KP. Culturally competent psychotherapy. Can J Psychiatry. 2003;48(3):161–70.
5. Aggarwal NK, Nicasio AV, DeSilva R, Boiler M. Barriers to implementing the DSM-5 cultural formulation interview: a qualitative study. Cult Med Psychiatry. 2013;37(3):505–33.

6. Sue S, Zane N, Nagayama-Hall GC, Berger LK. The case for cultural competency in psychotherapeutic interventions. Annu Rev Psychol. 2009;60:525–48.
7. Fung K, Andermann L, Zaretsky A, Lo HT. An integrative approach to cultural competence in the psychiatric curriculum. Acad Psychiatry. 2008;32(4):272–82.
8. Bateman A, Fonagy P. Mentalization based treatment for borderline personality disorder. World Psychiatry. 2010;9(1):11–5.
9. Bateman A, Fonagy P, editors. Handbook of mentalizing in mental health practice. Washington DC: American Psychiatric Publishing; 2012.
10. Multiple Authors. Resource document on cultural psychiatry as a specific field of study relevant to the assessment and care of all patients. In: Resource Documents. American Psychiatric Association; 2013.
11. Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. J Natl Med Assoc. 2008;100:1275–85.
12. Kirmayer LJ. Rethinking cultural competence. Transcult Psychiatry. 2012;49:149–64.
13. Kirmayer LJ. Cultural psychiatry in historical perspective. In: Bhugra D, Bhui K, editors. Textbook of cultural psychiatry. Cambridge: Cambridge University Press; 2007. p. 3–19.
14. O'Byrne M. Appendix F1: A review of cross-cultural training in mental health. In: Report on the evaluation of a cultural consultation service in mental health. McGill University. 2001.
15. Moodley R, Palmer S. Race, culture and other multiple constructions: an absent presence in psychotherapy. In: Moodley R, Palmer S, editors. Race, culture and psychotherapy: critical perspectives in multicultural practice. New York: Routledge; 2006. p. 11–26.
16. Lakes K, Lopez S, Garro L. Cultural competence and psychotherapy: applying anthropologically informed conceptions of culture. Psychothe Theory Res Pract Train. 2006;43:380–96.
17. Coleman HLK. Multicultural counseling competencies in a pluralistic society. J Ment Health Couns. 2004;26(1):56–66.
18. Kirmayer L, Fung K, Rousseau C, Lo HT, et al. Guidelines for training in cultural psychiatry. Can J Psychiatry. 2012;57(3):S1–S16.
19. Patterson CH. Do we need multicultural counseling competencies? J Ment Health Couns. 2004;26(1):67–73.
20. Weissman J, Betancourt J, Campbell E, et al. Resident physicians' preparedness to provide cross-cultural care. JAMA. 2005;94:1058–67.
21. Kirmayer LJ. Empathy and alterity in cultural psychiatry. Ethos. 2008;36:457–74.
22. Whaley A, Davis K. Cultural competence and evidence-based practice in mental health services: a complementary perspective. Am Psychol. 2007;62:563–74.
23. Kirmayer L. The cultural diversity of healing: meaning, metaphor, and mechanism. Heart Views. 2013;14(1):39–40.
24. Epstein RM, Siegel DJ, Silberman J. Self-monitoring in clinical practice: a challenge for medical educators. J Contin Educ Health Prof. 2008;28(1):5–13.
25. Schön DA. The reflective practitioner: how professionals think in action. New York: Basic Books; 1983.
26. Louie AK, Roberts LW, Coverdale J. The enculturation of medical students and residents. Acad Psychiatry. 2007;31(4):253–7.
27. Wellbery C. The value of medical uncertainty? Lancet. 2010;375(9727):1686–7.
28. Hansen JC, Gray LA, Ladany N, Walker JA, Ancis JR. Psychotherapy trainees' experience of counterproductive events in supervision. J Couns Psychol. 2001;48(4):371–83.
29. Wald HS, Reis SP. Beyond the margins: reflective writing and development of reflective capacity in medical education. J Gen Intern Med. 2010;25(7):746–9.
30. Jenks AC. From "lists of traits" to "open-mindedness": emerging issues in cultural competence education. Cult Med Psychiatry. 2011;35(2):209–35.
31. Bartoli E. Religious and spiritual issues in psychotherapy practice: training the trainer. Psychother Theory Res Pract Train. 2007;44(1):54–65.
32. Galtung J. Violence, peace, and peace research. J Peace Res. 1969;6:167–91.
33. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998;9:117–25.
34. Kirmayer LJ. Embracing uncertainty as a path to competence: cultural safety, empathy, and alterity in clinical training. Cult Med Psychiatry. 2013;37(2):365.
35. Littlewood R. How universal is something we can call 'therapy'? Some implications of non-western healing systems for intercultural work. J Interprof Care. 1990;5(2):49–65.
36. Guzder J, Rousseau C. A diversity of voices: the McGill 'Working with Culture' seminars. Cult Med Psychiatry. 2013;37:347–64.
37. Milkavcic A, LeBlanc MN. Culture brokers, clinically applied ethnography, and cultural mediation. In: Kirmayer LJ, Guzder J, Rousseau C, editors. Cultural consultation: encountering the other in mental health care. New York: Springer; 2014. p. 115–37.
38. Geertz C. From the native's point of view: on the nature of anthropological understanding. In: Schweder RA, LeVine RA, editors. Culture theory: essays on mind, self, and emotion. New York: Cambridge University Press; 1987.
39. Kirmayer L. Psychotherapy and the cultural concept of the person. Transcult Psychiatry. 2007;44(2):232–57.
40. Hansen H, Dugan TM, Becker A, et al. Educating psychiatry residents about cultural aspects of care: a qualitative study of approaches used by U.S. expert faculty. Acad Psychiatry. 2013;37(6):412–6.
41. Rousseau C. Incertitude et clinique transculturelle. Evol Psychiatr. 2002;67(4):764–74.
42. Beiser M. Culture and psychiatry, or "the tale of the hole and the cheese". Can J Psychiatry. 2003;48(3):143–4.
43. Aggarwal N, Rohrbaugh R. Teaching cultural competency through an experiential seminar on anthropology and psychiatry. Acad Psychiatry. 2011;35:5.
44. Anderson NB, Whaley AL, Davis KE. Cultural competence and evidence-based practice in mental health services. Am Psychol. 2007;62(6):563–74.
45. Gelso CJ, Leong FTL, López SR, Lakes K, López SR, Garro LC. Cultural competence and psychotherapy: applying anthropologically informed conceptions of culture. Psychother Theory Res Pract Train. 2006;43(4):380–96.