Jason N. Linder, PsyD
Relationship and Trauma Insights

The Perilous Blind Spots of Notions of Cultural Competence

Why "cultural humility" instead of "competence" better accounts for power.

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KEY POINTS

- **Notions of "cultural competence" emphasize learning differences between groups and overlook the structures that keep the dominant group in power.**
- **Merely studying "cultural differences" underscores between-group differences over "within-group" differences.**
- **For healthcare providers, understanding cultural differences isn't enough; they must understand power dynamics and uneven resource distribution.**

Despite being a cherished ideal in psychotherapy for decades, the term "cultural competence" has become increasingly flawed. While largely well-intentioned, it has poorly accounted for the power dynamics present not only in healthcare but also in broader institutional, geographic, educational, legal, and health settings, among others. It has overlooked social injustice and contextual and structural influences essential to someone's "culture."

"Cultural competence" was coined by anthropologist James Green in 1982, and then disseminated to the fields of medicine (see Tervalon & Murray-Garcia, 1998), social work, psychology, psychotherapy, and counseling. It is based on classifying culture by race and ethnicity. It has emphasized prior assumptions of cultural difference among ethnic groups. It was a good start toward embracing diversity but dangerously insufficient in 2022.

These classifications easily stereotype people, dismiss key intragroup differences and areas where they don't apply, and consider culture as a monolith. They overlook the reality that there are often more within-group than between-group differences among many categorized in certain groups. For example, the classification of "Asian," ubiquitous in important surveys like the census and sign-up forms, can overlook differences between Cambodian, Korean, and Japanese. While possibly inadvertent, *an unspoken implication in notions of "cultural competence," in certain contexts, used by certain professionals, can be that the better we understand "them," the more power and control we can keep over "them."*

Limitations of "essentializing" culture

Becoming "competent" in someone else's culture is largely untenable, especially if we have never been immersed in it. "Culture" is too nuanced for health professionals to "master." "Essentializing" culture (breaking it down into particular and predictable fixed traits and attributes that can be studied and "mastered") has become a disparaging form of "otherizing," and risks colluding with the power of the dominant group: White, cis-gendered, middle- and upper-class men.

The issue with "other" as a cultural, racial, or ethnic classification

When putting humans into cultural or ethnic categories, there's often an "other": White or Latino, Asian, Black, etc. The "other" focus implies that the default is White, and "others" are non-white, non-cisgender, non-English-speaking, non-Christian, non-heterosexual, etc. So, notions of competence are most flawed because they overlook the dominant status of the White group, the status quo of power over marginalized groups, and depend on overly formulaic prescriptions about how to do healthcare with "them."

More equitable and inclusive replacements

"Cultural humility" (Fisher-Borne, Cain, & Martin, 2015; Tervalon & Murray-Garcia, 1998) is a promising replacement. It acknowledges the fluidity of culture and pushes individuals, communities, and institutions to scrutinize social inequities. Humility acknowledges differences in power and challenges injustice and related barriers at the broader levels outside of the client's immediate social web.

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The shift from competence to humility is from an expert stance of understanding "others" to emphasizing accountability in addressing institutional barriers, power dynamics, and inequities that impact marginalized clients. For instance, the oil fracking in Colorado, Louisiana in neighborhoods with low-income Latinx communities (among many other areas in the U.S.) is associated with negative health outcomes. Low-income communities also tend to be more dangerous, less sanitary, and less resourced. *This is not a reflection of cultural characteristics, but systemic racism* (institutional and organizational practices that privilege Whites over diverse groups). The same applies to health disparities in diverse groups, such as suffering much financially, emotionally, and physically from the pandemic.

The over-representation of children of color in the welfare system and adults of color in correctional systems are more about policies and institutions that fuel disenfranchisement and less about cultural attributes. I could say the same about "redlining," the practice of excluding people from loans and mortgage based on their race. Whites owning substantially more wealth than Blacks is not about cultural properties but systemic or structural racism (Yearby, Clark, & Figueroa, 2022).

"Cultural equity," like humility, examines institutions and systems of subordination across and within cultures. Equity specifically examines the relations between power, privilege, oppression, family, and communal life. While competence aims merely to learn a group's history, values, and attributes, humility and equity strive to reduce oppression and injustice. While competence stresses self-awareness, knowledge of between-group differences, and encourages health practitioners to be more comfortable with differences, humility, and equity add a thorough assessment of the inherent power disparities in therapist-client or doctor-patient relationships. Competence has also focused primarily on race or ethnicity, problematically deemphasizing other germane disparities, such as socioeconomic status (SES), ability, age, size, height, language, sexual orientation, gender identity, among others.

Key takeaways for health providers

"Cultural competence" is not merely a set of skills and techniques acquired through rigorous training. While competence emphasizes knowledge acquisition, humility and equity stress responsibility at individual and institutional levels. While competence would imply that problems come from a lack of knowledge or awareness, humility and equity recognize power differentials and call for action and changes in attitudes about diverse clients and the broader forces that subjugate them. As stated, clients and patients from disenfranchised communities have less access to quality services, a lack of linguistically and culturally appropriate services, financial barriers, scarce time, and limited knowledge of resources available to them.

To lead and effect change for clients and patients as a healthcare provider, a technical and knowledge-based competence focus will not suffice. Training in humility-building (cultivating more curiosity and less of an expert-stance) and equity-appreciation (ensuring there are space for diverse groups) are keys to building improved relationships between health professionals and patients or clients. Instead of merely studying cultural differences and becoming "competent" in them, we begin to make a key difference when we attend to the equitable distribution of resources and confront unjust politics, practices, and policies, and examine how they influence one's "culture." This is what cultural equity, humility, and responsiveness are all about.

References

Almeida, R., Hernandez-Wolfe, P., & Tubbs, C. (2011). Cultural equity: Bridging the complexity of social identities with therapeutic practices. International Journal of Narrative Therapy & Community Work, (3), 43.

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. Social Work Education, 34(2), 165-181.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of health care for the poor and underserved, 9(2), 117-125.

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About the Author

Jason N. Linder, Psy.D., LMFT, is a licensed bilingual (Spanish-speaking) therapist specializing in relationship, trauma, addiction-related, and mindfulness therapies.

Online: Dr. Jason N Linder, PsyD, LMFT, Facebook, Instagram, LinkedIn, Twitter

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