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Letter to the Editor

Cultural humility: A skill to develop in clinical training[☆]



Humildad cultural: una habilidad que desarrollar en la formación clínica

Dear Editor,

Due to the multiple physical, economic and emotional effects derived from the confinement for the new pandemic, mental health professionals will soon (if not already) focus their efforts on the care of a growing group of people with psychological and psychiatric support needs. To provide this support, we are obliged to look at the skills mental health professionals need to develop and strengthen in terms of their training in assessment, diagnosis and intervention. In psychology training, the skills for clinical interviews, applying psychological tests to support the clinical diagnosis, formulating cases following one of the various theoretical approaches, and diagnosing based on the ICD-11 and DSM-5 criteria are the essentials. Some of these skills need to be adjusted to current conditions. For example, training in conducting clinical interviews through video calls, the ability to carry out immediate interventions at a distance, in situations where the person being assessed manifests behaviours that put their life or that of others at risk; the adaptation of tests for online application, with the respective understanding of the new source of variation, and introduction of measurement error when interpreting the results.

Added to all that, one aspect of training, which, in my opinion, we need to start talking about with trainees in psychological and psychiatric assessment and intervention, is cultural humility. The humility of the therapist as a virtue¹ is increasingly being highlighted as one of the fundamental skills for the success of psychological interventions². Recent theoretical approaches³ propose that humility has three constituent elements: openness, precise self-assessment, and orientation towards others. Additionally, three types have

been proposed: relational, cultural and intellectual. The first, concerning humility in relationships with others; the second, focused on manifest humility towards cultural beliefs and difference; and the third, in relation to the points of view and ideas of others. Training in any one of these aspects should have repercussions on the other two. I particularly focus on cultural humility, as I believe it is necessary to educate trainees about the importance of inclusion and integration of the cultural differences we have in our country as a central part of the assessment and intervention processes.

Cultural humility is defined as, “ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client (or supervisee)”⁴. One of the most deeply rooted prejudices in our clinical disciplines is that the mechanisms that underlie disorders respond to general elements, and sensitivity to cultural factors is of little relevance in the analysis of cases. Even despite the repeated call to recognise Colombia as a country of regions, clinical training processes seem to show a tendency towards cultural homogenisation, assuming that each trainee can transfer knowledge to their particular culture (if they come from another region of the country) or that, when practising their profession, they will only assess people from the region they are studying in, putting aside, as collateral, the chance they might have to assess someone from outside that region.

Among the many shortcomings that have become apparent during the pandemic, two of the main ones are the differences in access to healthcare and behaviours in response to the social measures applied to slow down contagion. We have often witnessed media reprimands directed at different areas

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of the country for not abiding by national decrees, or for the apparent lack of group insight to follow the recommendations of physical distancing, hand washing and face masks. However, interventions by representatives of the health authorities seldom refer to the particularities of each region in terms of their cultural practices in hygiene, community life and clothing. Similarly, when asked for their opinion on the matter, many healthcare professionals speak only in general terms, and more than a few of us have felt a touch of disapproval towards the cultural practices of many of our fellow citizens. This does not mean that certain group behaviours may or may not be justified, it means that our views need to be run through a bigger sieve guided by cultural humility to interpret regional conditions.

Cultural humility means being open to the perspective of the other in terms of their beliefs and what their cultural diversity means to him or her. So, this means that first of all, we have to stop ourselves from making evaluative judgements in our assessments and interventions without first understanding the particularities of those involved. Many trainees in clinical training will have to support processes in another region of the country with cultural differences from the one in which they were trained. If they are not given help and guidance to develop cultural humility, they are likely to simply repeat the cycle of imposition and criticism that is so common in our context, and they will lack the skills necessary to carry out satisfactory and beneficial interventions for their clients or patients.

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