Research Update

Over the course of the two decades of HIV prevention and treatment, the target population for interventions has broadened and diversified. At the same time, HIV has continued to hit hardest those populations, such as men who have sex with men, people of color, and injection drug users, that do not fit the stereotypical image of mainstream U.S. culture. As a result, researchers and HIV providers have come to recognize the importance of delivering interventions, including counseling, in ways that speak to people of varied backgrounds and needs.

There is a substantial body of research about culturally competent health and mental health care. Since the early 1990s, the research on culturally competent HIV prevention and counseling has grown. There are two main schools of thought about cultural competence. The first suggests that counselors should learn beliefs and norms of the specific cultures they are working with and mirror those cultures in order to, as it were, speak the client’s language. The second suggests that culturally competent counselors focus on learning skills such as openness and active listening that allow them to uncover an individual client’s culture and level of acculturation in the course of the counseling session. Recently, researchers have reexamined how counselors and practitioners view “culture” and the cultural models on which prevention strategies are built. This examination has looked at how these models and definitions may perpetuate the perception that clients who are different are “outsiders,” and how this perception may impede efforts to reach those in need of services.

Demographics of HIV-Related Risk

The demographic portrait of the epidemic offers a window on the diversity of clients. According to 2002 data from the Centers for Disease Control and Prevention (CDC), based on statistics from 30 states that require reporting of HIV infection, 54 percent of all new HIV infections in the United States were among Blacks, 32 percent were among Whites, 13 percent were among Hispanics, and 1 percent were among people of other ethnicities. In addition, Black and Hispanic people comprised more than 60 percent of all people living with AIDS.

In 2002, men accounted for 71 percent of all new HIV infections, while women accounted for 28 percent (children accounted for 1 percent). For both men and women in 2002, 44 percent of estimated new HIV infections were attributed to male-to-male sexual contact, 35 percent to heterosexual contact, and 16 percent to injection drug use. Finally, in 2002, 12 percent of new HIV infections were among people younger than 25, more than 63 percent were among people ages 25 to 44, and almost 25 percent were among people older than 45.
Defining Culture and Competence

Since early in the epidemic, there has been general agreement that cultural-related considerations should be central to the planning, implementation, and evaluation of health promotion and counseling programs.1,10,11

The term “cultural competence” relates to the ways in which cultural issues are addressed in such arenas; it has been examined and defined by various commentators.7,11-13

At a minimum, cultural competence requires that services be provided in the languages of the client populations a program serves. As fundamental, perhaps, is the idea that cultural competence is anything that contributes to the perception by people of diverse cultural backgrounds that services are legitimate. Because it is so intimately related to effective service delivery, cultural competence is required by many professional codes of ethics,14 and it may lead to lower costs of care, since people who receive culturally appropriate services use fewer crisis resources.3,15

Obviously, a definition of cultural competence is dependent upon definitions of “culture.” While researchers have defined the word in various ways,2,6,7,12 Barbara Van Oss Marin reflects the general consensus by describing culture as “a particular set of values, norms, attitudes, and expectations about the world that shapes the personalities of those reared in that culture.”16

This definition avoids the problem that others have identified: in the HIV prevention field, as in other areas, “culture” may refer only to racial and ethnic minority status, even though White and heterosexual people, for example, were also raised with values, norms, attitudes, and expectations.2 Others warn that when only non-European peoples are seen as having “culture,” their non-European ways are defined as barriers to their progress, subtly linking the ideas of “culture” and “barrier.”5,9

Still others suggest that culture is influenced not only by racial or ethnic background but also by other demographic factors such as age, socioeconomic or immigration status, sexual orientation, and history of oppression.1,17

Behavior and motivation for behavior.2,18 the expression of symptoms of disease,11 and treatment-related decision making and adherence are often affected by a person’s cultural background. Behaviors that may lead to HIV transmission “are rarely the direct product of merely a deficit of knowledge, motivation, or skill but instead can have layered meanings within a given, complex personal and social-cultural context.”19 This is important, because a counselor may perceive a client from a culture that is different from the counselor’s as having incorrect beliefs or as misunderstanding the nature of his or her own concerns and conditions. Providers may react by “educating” clients rather than responding to their needs and may, in turn, miss an opportunity to intervene effectively within the client’s own cultural framework.

In addition, understanding all of the factors that contribute to a person’s world view—those that are specific to the individual as well as those that are general societal conditions—may be crucial to cultural competence. Societal reactions such as racism and homophobia increase HIV-related risk and diminish access to both preventive and medical care services.8,10,17

For example, in one study, a group of Latino gay men who were defined by the researchers as participating in risk-related sexual behaviors reported more experiences of homophobia, racism, and financial hardship than a group exhibiting less risky behaviors.17 Counselors should examine the ways that being part of any marginalized class, including substance users or poor people, could prevent clients from accessing services as a result of internalized shame, in response to judgments made by service providers, or because of institutionalized discrimination.

Learning key facts about different cultures broadens a counselor’s perspective, but these facts alone do not constitute cultural competence. Instead, they may lead to complacency and stereotyping.

Finally, culture is a moving target. Acculturation into mainstream U.S. culture may change the effect of a person’s culture on his or her behavior. For example, studies have shown that as some male Latino immigrants become more acculturated to the United States, they may be more likely to use substances before sex.20

Presentation v. Content Strategies

These findings suggest that, consistent with the definition of cultural competence, providers must work to understand, and provide relevant services to, those who do not share their cultural backgrounds.4,5 If a client does not trust or understand an HIV test counselor, for example, and hesitates to honestly disclose feelings, sexual practices, substance use, or symptoms of illness during a counseling session, the session may fail to uncover the most relevant risks or concerns. It may also fail to offer clients steps that might be most helpful to protect themselves and their loved ones and partners.

Two prevailing approaches to cultural competence are “presentation” and “content” strategies.2 Presentation strategies use visual images or the language of a specific racial or ethnic group to attract clients of that group. For example, a program might hang artwork specific to a particular culture it wishes to attract or hire people of the same racial or ethnic background or appearance (for instance, younger looking
people). Early efforts at cultural competence focused on “ethnic matching,” that is, employing providers who were the same culture or who spoke the same language as the target population. This presentation strategy has been successful in some venues, but has not made a difference in others. Some theorists point out that being of the same race or ethnicity does not ensure cultural competence or effectiveness. Some go so far as to call cultural matching a form of “cultural chauvinism,” asserting that it assumes that only those of the same skin color can understand each other.

Content strategies concentrate on integrating concepts and themes from a particular culture into the design of the program. For example, a provider might look at factors that are both specific to a culture and related to HIV transmission and use these factors to facilitate client discussions on these themes of behavior and risk. Using information gathered from the clients of a particular culture to direct prevention messages and inform counseling sessions would be an example of a content strategy.

Both content and presentation strategies are based on the idea that there are specific qualities about a culture that define that culture and that this knowledge should be absorbed and applied by programs and counselors to work with specific groups. Unfortunately, these assumptions may lead to superficial and flawed approaches to counseling: a counselor and a client may share the same ethnicity, but may not identify with the same culture.

For instance, in one agency, hiring a Puerto Rican counselor to work with Mexican migrants was a presentation strategy that failed because the provider spoke a different Spanish dialect. Similarly, a client may choose one of several cultural identities as his or her primary identity. For example, an Asian American man might identify primarily as gay, as a “top,” or as a drug user, leaving a counselor who is looking at the client only as “Asian” struggling to connect.

Richard Dana and his colleagues developed a checklist for agencies seeking to become more culturally competent that includes both presentation and content strategies. This checklist consists of five criteria: staff and policy attitudes; services; relationship to community; training; and evaluation. Each of these criteria has subcategories. For example, under staff and policy attitudes, an agency can look at implementing bilingual/bicultural approaches (presentation strategy); employing “culture brokers,” people of the target culture who can help bridge clients from their frame of reference to mainstream cultural concepts, (presentation and content strategy); matching client and staff (presentation strategy); and ensuring that agency environment reflects culture (presentation strategy), among others.

Patricia Vinh-Thomas and her colleagues developed their own research-based HIV-specific checklist that also uses content and presentation strategies. This checklist includes four general criteria, encompassing 33 indicators such as: ability to assess need among target population; mechanisms and structures to identify cultural, linguistic, and socioeconomic issues among target population; and ability to provide program to intended target population. Although Vinh-Thomas’s tool breaks down the tasks much more than Dana’s does, neither checklist answers the question of how to implement improvements when the checklist uncovers deficits in cultural competence.

Following Clients toward Competence

Other researchers and practitioners suggest that counselors take an approach that focuses on the client’s experience of his or her background and present situation. This approach encourages practitioners to shed the idea that the client whose culture is different from the counselor’s is “other” and to challenge any stereotypes or assumptions that the counselor may have about this “other” culture.

Amanda Houston-Hamilton and Noel Day elaborate on this approach, calling it “working downhill.” They suggest asking a client to describe his or her own experience in order to discover his or her beliefs about substance use, sex, treatment, and a range of other HIV-related topics. Using these beliefs as a basis for a conversation about HIV and risk is easier and works better than trying to change a client’s cultural attitudes to fit a particular programmatic approach.

For example, most HIV counselors working in urban settings have heard the terms “top” and “bottom” to describe aspects of gay male sexual behavior, and simply understanding these terms can help a counselor understand, in general, certain sexual behavior. However, since these terms may have more specific meanings for any individual, cultural competence may require a more inquisitive approach. In response to a client’s assertion that he is a “top,” for instance, a counselor might ask the client what that term means to him: is he the insertive partner? The dominant partner? Is he always the “top”?

Counselors can gain insights into a client’s world by asking questions instead of making assumptions about the way clients look or the labels clients use to describe themselves.
Houston-Hamilton and Day then recommend adapting messages and materials to reflect these individual definitions rather than using an approach that is based on an assumed cultural framework (or stereotype) that may not fit. For example, instead of struggling to get a client to absorb and accept the “facts” about the origins of HIV and how it is transmitted and treated (working uphill), the authors suggest that “it makes sense to allow individuals their particular understanding of illness as long as these ideas do not impede the movement of counselor and client toward an agreement on safer behaviors” (working downhill).

Mindy Thompson Fullilove points out that while stereotypes reinforce group boundaries and contribute to a sense of belonging, they also interfere with counselors’ being able to understand and see their own assumptions about their clients. She notes, for example, that a gay counselor with unresolved issues about his sexuality can bring fear and judgment into a counseling session because of his own internalized stereotypes about gay men—even if he is working with someone of his identified race, gender, and sexual orientation. Thus, even “matched” counselor-client pairs can run into issues of projection, stereotyping, and cultural error.

Similarly, Fullilove warns against the “factoid” approach, that is, relying solely on key facts about different cultures to constitute cultural competence. For the reasons she and Houston-Hamilton state, these bits of information can cause a counselor to become complacent about his or her cross-cultural knowledge, fall into stereotyping, and fail to ask the questions that are crucial to building trust and to understanding what steps it would make sense for the client to take.

**Invisible Culture**

Because many program administrators and counselors have been steeped in an Anglocentric society, some versions of cultural competence view “culture” as something that only non-Anglo people possess, and that “culture” equals “other-ness” and implies barriers to change. This view continues to marginalize certain groups, even as it attempts to reach them. At the same time, this attitude can lead a counselor to overlook differences in how people who might look “mainstream” think and feel about their own behaviors, sexuality, disease, and other concepts. Power imbalances in the counselor-client relationship and those that arise from the perception that White is “mainstream” while non-White is “other” also create hidden barriers that can get in the way of establishing trust, rapport, and understanding.

Looking through the lens that everyone has a “culture,” the counselor’s task becomes not so much one of overcoming the barriers of the “other’s” culture. Instead, the task becomes one of discovering what beliefs and values each person holds and working within these beliefs and values to find motivation and opportunity for education and change. This includes counselors examining their own cultural background and how it affects their work.

At the same time, other commentators have been examining the very basis on which HIV prevention strategies have been built. They point out that the underlying theories of HIV prevention, counseling, and risk reduction employ personal responsibility, social learning, and rational-cognitive approaches to get across their messages. These theories work well for many people who are comfortable with an individualistic approach, but not so well for people from cultures where family, community, and social perceptions play a larger part in an individual’s decision-making process.

Thus, questions such as “How can you be healthier?” or “What steps could you take to reduce your risk of HIV?” might not motivate or even be appropriate for someone of a culture in which people are interdependent. For such clients, separating themselves from their families or communities in order to protect themselves might be alienating and unhealthy rather than liberating and empowering. In these cases, prevention aimed at an entire family or a community might work better.

In a counseling session, the counselor might focus on helping a client explore the ways in which family and community could support health and well-being.

One study looked at ways of changing prevention strategies to reach people who have a more community-based orientation. In one neighborhood, certain stores were targeted as community gathering places for recently immigrated Bangladeshi adults. Prevention staff first talked to the store owners, who in this case served as “cultural emissaries,” about condom use and HIV transmission. After getting the store owner’s buy-in, staff put condoms and HIV information in the store. This method of condom and information dissemination seemed to work for this population, because the message was able to surface in a culturally appropriate manner: someone known to and respected by the community shared the resources in a way that was non-threatening and public.

**Conclusion**

The range of theories about how to bridge difference between counselors and clients is large enough to offer many alternatives for practice. Defining culture broadly to include “mainstream” beliefs as well as those of more marginalized groups opens the door to greater understanding when working with individuals.

There are many ways to experience an individual’s culture—whether related to age, gender, race and ethnicity, sexual orientation, or socioeconomic class—and counselors who approach these characteristics with openness and curiosity are more likely to truly connect with their clients. In this way, cultural competence for any individual counselor is a continual process. Since at its essence, cultural competence requires a willingness to not know, to not assume, and to learn from clients, it is always evolving.
Implications for Counseling

Counselors who ask themselves “Am I culturally competent?” may initially find the question overwhelming. Culture is a complex idea, involving not only race and ethnicity, but also membership in a variety of groups, each with an influence on a person’s world view. But the task of developing a culturally sensitive approach to counseling does not have to be intimidating. In many ways, culturally sensitive counseling extends familiar skills: those that relate to client-centered counseling.

**Cultural Awareness and Self-Awareness**

Cultural sensitivity begins with cultural awareness, the recognition that people have values, beliefs, and practices that differ from one’s own. Of importance to HIV counseling, culture may influence sexual activities and drug use practices, beliefs about illness and death, and values regarding all of these.

The first step toward cultural awareness for counselors is to explore their own cultural perspectives and biases. Without this understanding, it is easy for a person to judge his or her world view as the only correct one. It may be especially challenging for White or heterosexual counselors to recognize the cultural lenses through which they view the world, since in the United States, the social message is that being White or heterosexual is the “mainstream” and “culture” is identified with minority status.

It is also important for a counselor to understand the power dynamic and “culture” of the counseling setting itself. Counseling is by nature an imbalanced power setting, endowing the counselor with authority. Counselors seek to create a climate that is open and comfortable as possible for clients, diminishing this imbalance without compromising appropriate boundaries.

To achieve this, counselors should be aware of how their own cultural beliefs and judgments affect their reactions to clients during each step of HIV counseling. When counselors who enjoy societal advantages based on race, gender, or sexual orientation, for example, counsel clients who do not enjoy these privileges, the already unbalanced power dynamics of the counseling session may be intensified. In this case, clients may experience marginalization rather than empowerment.

**Barriers to Trust**

Historical racism, sexism, and homophobia, both in society and in the medical establishment, build barriers for many people seeking to access health care, including HIV testing. In particular, there is a legacy of mistrust around the treatment of sexual issues by the American medical establishment. For example, for more than 40 years, African American men with syphilis were lied to and forced to go without treatment so that their symptoms could be studied during the Tuskegee medical experiments; gay and lesbian people were treated for their “mental illness” with electroshock therapy; and Puerto Rican women were sterilized without their knowledge or consent. Awareness of such examples of racist policies in American medical history can help counselors understand some of the fear and mistrust clients may bring to HIV counseling and testing.

Racism, sexism, and homophobia can have powerful effects on self-esteem, communication style, body image, and feelings of control, which in turn can diminish a client’s sense of self-protection, ability to negotiate safer sex, and capacity to employ harm reduction strategies. Counselors can ask themselves, “How does the stress of the HIV counseling session combine with the feelings a client facing racism, sexism, or homophobia has already experienced?” and then consider ways to build rapport in this context.

Another group with a history of painful encounters with the medical establishment are substance users. Many clients who have experienced judgments about substance use may be afraid to disclose the details of their practices. Counselors can consider ways in which substance users create their own culture and community, as well as the ways that this culture may influence HIV risk and attempts to change risk behaviors.

**Many Cultures, Many Identities**

Each person possesses multiple cultural memberships. Memberships such as race, ethnicity, and gender may—or may not—be clear, while sexual orientation, substance use, and religious affiliation are just a few “cultural identities” which are often invisible. Counselors can avoid the trap of stereotyping clients based on one cultural experience or membership. For example, while it is useful to be aware of the legacy of racism in the medical establishment, counselors should not assume that all people of color mistrust medical approaches.

It is equally important to avoid overidentifying with clients based on a common cultural membership. For example, a client and counselor who are Latino, male, and have sex with men—but who have different religious beliefs, and quite possibly different sexual identities—may view options around sex and risk quite differently. Similarly, a counselor in recovery cannot assume that risk reduction strate-
gies that worked for him or her will work for a client who is using drugs, although the counselor’s experience may provide a useful perspective.

Given all the possible identities and cultural memberships, and the ways they combine in each individual client, some researchers have argued that all encounters demand cross-cultural counseling skills. There is always some gap in experience and identity that must be bridged between one person and another.

How clients identify themselves and how they interpret their cultural experiences is a complex process. By actively listening to a client throughout the session, counselors can pick up on cultural memberships with which the client most closely identifies, and those that are most strongly related to HIV-related beliefs and practices. For instance, one HIV test counselor, after trying to talk to a client about his experience as a man of color in the gay community, was told by the heavyset client: “A better question to ask would be, what’s it like to be in this body?” Another important question for counselors to ask is, from where does the client draw strength and support, and how are these sources related to cultural identity and the possibility of behavior change?

The Power of “Not Knowing”

If a counselor typically works with clients of a specific culture—for example, if a counselor sees many middle-aged, urban gay men or young African American women or rural White non-injection drug users—it may be helpful for that counselor to do some work to understand the key cultural institutions and influences that are common to this group of clients. Some of these influences might include language—both foreign and a subculture’s vernacular or slang; history; the role of the family—biological and non-biological, nuclear and extended; the role of religion or spirituality; key social institutions and ways of socializing; and traditions and customs, particularly as they relate to HIV-related risk.

It is equally important, however, for counselors to avoid “arming” themselves with information, undermining their curiosity and leading them to believe they already “understand” clients. Knowledge can enrich a counselor’s sense of curiosity about the diversity of experiences in the world. But it cannot replace the process of learning from clients about their individual values, beliefs, and behaviors.

The stance of “not knowing”—of not making assumptions—may mean counselors will spend more time asking for clarification about, than interpreting, a client’s behaviors. Amanda

References


Case Study

At the end of a busy antibody test counseling shift, Gloria, a 37-year-old African American test counselor, looks up to see Susan, a 24-year-old White woman and a new counselor, leaning against the door frame and looking uncomfortable. Gloria, an experienced counselor, invites Susan in and asks her how her last session went.

“She was negative, thank God,” Susan says. “But, there were a couple things I wanted to check out with you. I feel kind of stupid, since we just had that class on cultural competence. Do you have time to give me some feedback?”

As Susan tells her story, it becomes clear that there were a few snags in Susan’s session with Louise, a 65-year-old African American woman and first-time tester. “Somehow we got sidetracked onto how the AIDS epidemic got started. At first, I felt really good talking about that, because I know a lot about it and I thought I could build trust by showing I was knowledgeable. But then it started cutting into our risk assessment time and I began to rush through the assessment questions. The client looked offended and got really quiet, and I was really conscious of being this White woman asking her these really personal questions.

“Finally I just said, ‘I’m new at this and I don’t feel like I’m doing a good job connecting with you. Can we go back a few steps? Is there a way I can be more helpful?’”

Gloria praises Susan’s decision to seek consultation. She says that she is familiar with African American clients asking about how AIDS began. “It sounds like you might have felt a little insecure, and here was a chance to show your credibility, but then you got sidetracked. How do you think it would have been for you to say, ‘A lot of people have asked me that, and there are lots of theories. What have you heard? What makes sense to you?’”

Susan agrees that this approach could have given her a better window into Louise’s world view.

Gloria continues, “And you’re right to think she might be checking out your credibility. This woman lived through Tuskegee. Still, remember to move on: everybody has a story, and listening to that story can take us to the next step, but stay focused on the client’s risk-related needs.”

“Another thing that I noticed was that you got rushed doing the risk assessment questions,” Gloria observes. “Remember, you aren’t just a White woman and a stranger: you’re young enough to be her daughter. And she has never tested before. She’s new to our ‘culture.’ Maybe going through the risk assessment abruptly felt intrusive. Sometimes, I introduce the assessment by saying, ‘I’d like your permission to ask you some personal questions—about things like sex and drugs. Your answers are confidential, and I hope we can use them to identify some steps that will help you protect your health.’ Probably the most important thing you can do with any client is to show respect and a willingness to listen.”

Gloria adds, “It sounds like you already know that, because your gut told you things weren’t working out and that you needed to reconnect with Louise. What happened when you acknowledged the problem and asked Louise what you could do to connect better?”

Susan says that Louise became a little tearful as she recounted how a friend from church had lost a son to AIDS. As Susan eased back into the risk assessment, Louise shared more openly. “She even ended up taking some textured condoms to use with her ‘special friend.’ I was a little surprised those would catch her eye.”

Gloria says, “So you were able to recover, and Louise helped you see where she needed to go next. Remember, our clients don’t expect us to know everything—about AIDS or about them. Be interested and learn all you can in the time that you have.” Gloria grins, “We’ll talk about your assumptions about senior citizens and sex next time.”
Test Yourself

Review Questions
1. True or False: Self-awareness and examination is an important step in becoming culturally competent.
2. True or False: The dynamic or “culture” of the test counseling setting is one in which power is naturally balanced between client and counselor.
3. Which of the following factors may influence a person’s cultural identity? a) race and ethnicity; b) gender and sexual orientation; c) substance use status; d) all of the above.
4. True or False: White people don’t have the same depth of culture as people of color.
5. A person’s culture may: a) make him or her confused about medical facts; b) influence decisions about sexual behavior and risk; c) make him or her more oriented towards interdependence than independence; d) b and c.
6. The counselor’s stance of “not knowing” means: a) counselors should remain open and curious about a particular client’s experience; b) counselors should not attempt to learn anything about a client’s culture; c) counselors should focus on interpreting client behaviors rather than asking for clarification; d) all of the above.

Discussion Questions
1. Why is it important for counselors to consider the impact of culture on their clients’ (and their own) lives? How does culture affect HIV risk and its reduction?
2. What are your cultural beliefs and assumptions about sexuality and HIV, and how do they affect your work when you meet with someone who you see as different than you?
3. What are some of the advantages and limitations of “cultural matching” in providing test counseling services?
4. How can test counselors help clients who may have experienced racism, sexism, or homophobia develop comfort and rapport in the test counseling process?
5. How do a counselor’s assumptions, stereotypes, and generalizations about a client’s culture hinder the process of helping the client make small changes to reduce risk?
6. How can counselors who want to develop their cultural competence go about doing so?
7. How has the idea of cultural competence evolved over the years? What strategies have you found most useful in bridging differences?
8. Have you ever found yourself surprised by something a client has revealed to you because it contradicted your assumptions about that client? How did you react, and how might you have reacted differently?

Answers
1. True.
2. False. The counseling situation naturally places counselors in positions of authority, but effective counseling works to minimize the power difference between counselor and client.
3. d.
4. False. “White” people—who actually comprise a large number of cultural and ethnic groups—have as much “culture” as any other racial group. Each cultural manifestation of White influences its members’ values, norms, attitudes, and expectations of the world.
5. d.
6. a.
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