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ORIGINAL PAPER

Families' and Practitioners' Use of Culture in Youth Mental Health Services: A Double-Edged Sword

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Abstract
Background Although the literature in medical anthropology and transcultural psychiatry has documented how cultural representations shape individual experiences and perceptions of psychosocial distress and its management, less attention has been given to what is actually meant when the concept of culture is used in professional practice, and how this may influence experience of care.
Objective The objective of this article is to explore what understandings of culture circulate in youth mental health practitioners' and families' narratives, and to analyse how different operationalizations of the concept may affect experience of services.
Methods This article draws upon the qualitative components of a larger mixed-methods research program on collaborative care in youth mental health. Semi-structured interviews were conducted in Montréal (Québec, Canada) with 39 parents, 48 youths and 29 practitioners about their experience of services, and with 26 practitioners about their experience of intercultural training. Data was analyzed using thematic and narrative approaches.
Results Results show that families and practitioners use a multiplicity of understandings of the concept of culture in their discourses as a narrative strategy to mediate dialogue in clinical encounters, either by engaging in it, avoiding it, or refusing it.
Conclusions The concept of culture and its use in the clinical realm can be seen a double-edged sword, both as a tool to reify stereotypes and inequalities, and as a means to mobilize representations towards cultural safety and transformative practices. Minority families' experiences of services may be improved by providing intercultural training and a supportive work environment to clinicians.

Keywords Youth Mental Health Care · Culture · Discourse · Dialogue · Cultural Safety · Intercultural Training

Introduction

Over the last few decades, a large body of theoretical and clinical writings in medical anthropology and transcultural psychiatry have documented how collective representations

Extended author information available on the last page of the article

shape individual experiences and perceptions of psychosocial distress and its management. This literature has emphasized the salience of cultural representations in clinical encounters, whether they be explicitly acknowledged or implicitly embodied by families and practitioners. However, less attention has been given to what is actually *meant* when culture is used in professional practice. To address this less studied aspect, this article will explore how various understandings of culture are used by practitioners and families in youth mental health (YMH) services in Montréal (Québec, Canada) and apply a cultural safety paradigm to analyze how different operationalizations of the notion of culture may affect families' and clinicians' experience of YMH services. In line with the literature (e.g., Carpenter-Song, Schwallie, & Longhofer, 2007; Gregg & Saha, 2006), our hypothesis was two-fold: that "culture" is an equivocal term, and that clinicians with intercultural training tend to conceptualize culture more as a process-based rather than an essentialist phenomenon. Based on our research results, we will argue that the concept of culture and its use in the clinical realm can indeed be viewed as a double-edged sword, in that it can be used as a tool to reify stereotypes and inequalities, especially among clinicians without intercultural training, or as a process of mobilizing representations towards cultural safety and transformative practices.

Attention to culture in mental healthcare: the cultural safety paradigm

In mental health services, it has been documented that ignoring cultural elements in clinical practice can lead to low-quality care, such as incomplete evaluations, diagnostic errors, inappropriate treatment plans, and non-compliance by patients and families (Adeponle et al., 2012; Alegria et al., 2010; Hansson et al., 2010; Kirmayer et al., 2007). As such, when faced with the necessity to take full account of cultural influences on mental health problems and care, practitioners and health systems attend to culture in terms of "cultural competence". Although often well-intentioned, some approaches to cultural competence tend to take the form of cookbooks that describe and attribute mental health beliefs and behaviors to specific ethnocultural groups. By minimizing intra-group variability and overlooking clinicians' cultural representations, such approaches tend to reify and essentialize culture, leading to the stereotyping of entire communities and decomplexifying the role of culture in clinical practice (Kirmayer, 2012; Kleinman & Benson, 2006). To avoid oversimplifications of culture, other approaches to the consideration of cultural diversity in healthcare have been proposed, such as "cultural humility", which describes a lifelong process of approaching cultural diversity from a humble position and impossible mastery of cultural knowledge (Tervalon & Murray-Garcia, 1998), and the notion of "cultural safety", which addresses issues of power and discrimination in health service delivery (Anderson et al., 2003; Papps & Ramsden, 1996).

In the late 1980s and early 1990s, "cultural safety" was coined by Māori nurse leaders and educators as a new approach to healthcare (Ramsden, 1990). One of the main leaders, Irihapeti Ramsden, later developed this concept further in her 2002 doctoral thesis (Brascoupé & Waters, 2009). Stemming from the sociopolitical context of Aotearoa/New Zealand where significant health disparities existed between Māori and European descendant populations, an important contribution to the conceptualization of cultural safety was the introduction of a critical perspective on the use of culture in the health sector (Papps & Ramsden, 1996; Smye et al., 2010). Whereas "Māori culture" was often used as an explanation for the poor

health statuses of Māori communities, the cultural safety approach brought back into focus the important influence of historical, political, and socioeconomic contexts on health and healthcare (Ramsden, 1990). Also central to the cultural safety approach is a shift in power in terms of determining the outcome and success of a healthcare intervention. In the cultural competence paradigm, clinicians and organizations are responsible for assessing the quality of care, whereas in a cultural safety paradigm, it is the person receiving services that has the last word (Ramsden, 2002; Robinson et al., 1996). Focus is also less on the benefits of culturally competent care and more on the risks of culturally unsafe care, making the cultural safety approach based less on the ideas of knowledge, competence, and expertise, and more concerned with the establishment of trust, respect, and equality (Brascoupé & Waters, 2009). In sum, the goal of culturally safe care is to ensure that the person or family receiving services feels welcome and accepted, does not feel discriminated against, and is not put at risk of cultural harm by both acknowledging and legitimizing cultural differences, and valuing diverse cultural identities (Smye et al., 2006; Papps & Ramsden, 1996; Williams, 1999). Initially developed in response to the consequences of colonization for Indigenous groups, the cultural safety approach has inspired a reflection on care for other sociocultural groups and contexts.

The objective of the article is to explore what understandings of culture circulate in YMH clinicians' and families' narratives, how culture is used in their discourses, and to what extent this use is embedded in a framework that might provide or hinder a feeling of cultural safety for families accessing services.

Methods

Research design and setting

This article is based on research findings from the qualitative strand of a large multisite and mixed-methods research program on collaborative care in YMH conducted in socioeconomically and culturally diverse neighborhoods, in Montréal. Two sets of data will be solicited for this paper and examined using a qualitative case study design (Creswell, 2003): (1) narratives from families and clinicians involved in YMH follow-ups in first line health and social services centers (Study I); and (2) narratives from clinicians about their experience of a specific intercultural training modality (Study II). Field notes were also collected throughout both studies, documenting the context of data collection activities along with researchers' reflexive accounts. Whereas the purpose of Study I was to look at families' and clinicians' overall lived experience of care (including but not primarily in terms of intercultural issues), the purpose of Study II was to look at clinicians' lived experience of intercultural training and at the place of culture in their clinical practice. The rationale for concomitantly exploring the two datasets is that intercultural training is often proposed as a solution to the difficulty of addressing culture in practice. Combining the analyses of discourses collected in two different discursive contexts but in the same clinical practice context (the case of culturally diverse Montréal neighborhoods) allowed us to complexify our understanding of "culture talk" in a specific setting and to explore its potential influence on the experience of care in terms of cultural safety.

Data collection

Study I: Starting in 2012, data was collected from youth and children receiving care (4 to 17 years old), their parents, and their principal health care workers to study the relationship between collaboration, types of interventions, and quality of services. All practitioners working in the participating sites were invited to take part in the project and to inform families about the study. Before deciding whether they would like to join the project, families who agreed to be contacted were provided additional information by the research team regarding participant involvement and study aims. The research team met with participating parents and their children either at home, in the clinic or in a research office, according to their preferences. A total of 217 families participated in the quantitative strand of the research and were contacted at three points in time to complete questionnaires: at the onset of services (T0), 6 months later (T1), and 1 year later (T2). A sub-sample of participating families (n=44) also agreed to take part in semi-structured interviews at T1 and T2. Research assistants obtained informed consent from participants and assent from children when 14 years or older, and then conducted interviews in French or English based on the participants' preferences. The assistance of a professional interpreter was provided when needed. Research was conducted in compliance with the ethics board of the participating sites. A total of 205 interviews were conducted between April 2015 and April 2017 by research assistants trained in qualitative research (including the first author), and covered the following themes: reasons for consulting, explanatory models of problems, trajectory of services, experience with care, and cultural adaptation of services. This article draws upon the qualitative component of the larger mixed-methods study (Study I).

Study II concerns practitioners' narratives about a specific training modality in intercultural YMH called Transcultural Interinstitutional and Interdisciplinary Case Discussion Seminars (TIICDSs). For more than two decades, these Seminars have been held in Montréal as a way of enhancing the intercultural competence of practicing YMH professionals and trainees. TIICDSs bring together professionals (approximately 25 participants per group) from various disciplinary backgrounds and institutions, including primary health care and social services organizations, youth protection services, and the education sector. Four different Seminar groups hold monthly meetings in four different neighbourhoods in the city of Montréal. Three of these four groups took part in the study, and one organization declined participation. TIICDSs consist of in-depth clinical case discussions lasting approximately three hours. Sessions are structured around an initial presentation made by one or more professionals involved with the family (either intra- or inter-institutional colleagues), followed by a group discussion on the case and recommendations to the presenters. During the Seminar, the group actively participates in case formulation and treatment recommendations, with a senior transcultural mental health clinician acting as facilitator and resource person. As part of the research program on collaborative care in YMH, a two-year evaluative study was conducted to document the impact of TIICDSs. Building on results from this study, semi-structured individual interviews were conducted by the first author with a sub-sample of Seminars participants to deepen our understanding of participants' experience in training. Twenty-six participants agreed to be individually interviewed. Research was conducted in compliance with the ethical board of the participating sites. Interviews were conducted between May and September of 2017 and covered the following themes:

reasons for attending TIICDSs, participants' cultural identities, and participants' perception and experience of Seminars.

Data analyses

Data collected during Study I and Study II was analyzed qualitatively using thematic and narrative analyses. All audio material was transcribed verbatim by a professional transcriber. Transcripts were then read, and interviews were synthesized in brief summaries and overview tables. Using the qualitative data analysis software *NVivo* (version 10), a thematic analysis of the transcripts was conducted to elicit the presence of culture in the narratives. This analysis emerged from an iterative process between the data, pre-existing codes, and emergent ones. A text-search was also conducted with the character sequence cultur* to ensure nothing was omitted during the previous coding phase. The third step of the analysis consisted in exploring how participants' narratives around these understandings of culture were articulated in more or less coherent discourses. By going back and forth between the transcripts and field notes gathered throughout the research process, the idea of using culture as a differentiated way of approaching "dialogue" slowly emerged. Inspired by a Bakhtinian approach that considers dialogue as a "polyphonic" and transformative process leading to the emergence of ideas (Bakhtin, 1984, cited in Seikkula & Trimble, 2005), three broad categories to qualify this mediating process of the notion of culture were then developed, namely: engaging in a dialogical encounter, avoiding dialogue, and rejecting dialogue. The final step of the analysis was to document the contexts of production and enunciation of these discourses by making analytical notes on elements, such as the identities of interlocutors, their attitudes, the time and place of enunciation, as well as the broader social, historical, political, and institutional contexts of the encounter. A narrative approach was favored, as a focus on participants' use of language hints at shifts in perceptions and assumptions around various subjects, as well as identifies the negotiating mechanisms in power relationships (Blommaert & Bulcaen, 2000). Using discourses as a window onto situated beliefs, knowledge, values, and attitudes, our analyses examined what participants considered as cultural and, by extension, as culturally different and how it should be attended to. Finally, throughout the analysis process, meetings were held among the research team to discuss findings and ensure the most systematic and transparent analytical process possible. In addition, the content of the paper has been discussed with people involved in the professional practice studied and with people who are less familiar with it, thus combining the strengths of the emic and etic perspectives. In this paper, some parts of interview extracts were altered to preserve participant confidentiality; for instance, changing or removing the names of families' countries of origin or the professions of clinicians.

Results

Characteristics of participants

A total of 112 participants were interviewed during Study I: 39 parents, 48 children or youth, and 29 practitioners. Most participants were met at two points in time (T1 and T2), for a total of 205 interviews. For Study II, 26 practitioners were interviewed once, at the end of

the TIICDS year. As shown in Table 1, families who participated in Study I presented a large degree of diversity in terms of geocultural regions of origins (based on parents' country of birth). Two elements are important to further note here. First, the fact that 6 families were of mixed origins, combining more than one geocultural area; and most importantly, the idea

Table 1 Characteristics of Interviewed Families

	Study I (N=44)*	
	N	**%**
Child Gender	18	40.9
Girl	26	59.1
Boy		
Child Age at T0	11	25.0
4–7 years	17	38.6
8–11 years	8	18.2
12–14 years	8	18.2
15–17 years		
(M=10,9 years; *SD=3,5)*		
Child Born in Canada	31	70.5
Yes	13	29.5
No		
Parent Gender (Interviewee)	35	79.5
Female	4	9.1
Male	5	11.4
Missing		
Parent Born in Canada (Interviewee)	22	56.4
Yes	17	43.6
No		
If not, number of years in Canada (M=12,0 years; SD=9,0; range 1–49 years)		
Parent Highest Level of Education	9	20.5
Secondary or less	5	11.4
Professional or college	24	54.5
University degree	6	13.6
Missing		
Family Income	9	20.5
Less than 20 000$	10	22.7
Between 20 000$ and 40 000$	2	4.5
Between 40 000$ and 60 000$	16	36.4
More than 60 000$	7	15.9
Missing		
Migration	18	40.9
Non-Migrant Parents	7	15.9
Mixed Parents	19	43.2
Migrant Parents		
Geocultural Areas of Origin**	5	10.4
Caribbean	3	6.3
Central and South America	3	6.3
East and South-East Asia	2	4.2
Europe	11	22.9
Middle East	24	54.5
North America	1	2.1
Sub-Saharan Africa	1	2.1
South Asia		

*Certain cases did not consist in a complete parent-child-clinician triad; thus, 5 youths participated by themselves, and 4 parents participated without their children. Additionally, 4 families had 2 children who participated instead of 1

**Six families were of mixed origins, and thus combined more than one geocultural area; therefore, the total exceeds 100%

that these categories are derived from the United Nations' statistical divisions, thus are far from representing culturally homogeneous entities.

As shown in Table 2, practitioners who were interviewed for Study I and II were mostly working in local health and social services centers, and the most represented domain of practice in both studies was social work. A large majority of participating practitioners were female and Canadian-born. Twelve professionals from Study I were also TIICDSs participants and one of them also took part in Study II.

Talking about culture

When questioned about whether YMH practitioners took their cultural background into account, certain parents and youths from Study I replied with ambivalent answers, stating that culture was "not important", while also providing illustrations of concerns on cultural issues elsewhere in the interview. Some participants also identified an ambiguity in the use of the term, as illustrated below:

[Interviewer: Do you feel that she [the clinician] took your culture into account?] We don't have any cultural… We really don't care about that. I don't know. I can't really answer that question because we never… When you say culturally, being religious-wise or ethnic-wise? I don't know. (Parent)

Culture… What do you mean by that? (Youth)

Table 2 Characteristics of Interviewed Practitioners

	Study I (N=29)		Study II (N=26)	
	N	**%**	**N**	**%**
Gender	26	89.7	22	84.6
Woman	3	10.3	4	15.4
Man				
Age	1	3.5	2	7.7
20–29 years	7	24.1	12	46.2
30–39 years	2	6.9	9	34.6
40–49 years	4	13.8	3	11.5
50–59 years	2	6.9	0	0.0
60 and more	13	44.8	0	0.0
Missing				
Born in Canada	21	72,4	21	80,8
Yes	3	10,4	5	19,2
No	5	17,2	0	0,0
Missing				
Organization	29	100,0	17	65,4
Health & Social Services	0	0,0	7	26,9
Youth Protection	0	0,0	2	7,7
Schools & School Boards				
Domain of Practice	9	31,0	16	61,5
Social Work	8	27,6	5	19,2
Psychology	6	20,7	4	15,4
Psychoeducation	5	17,2	0	0,0
Art Therapy	1	3,5	1	3,9
Other				

[Interviewer: Do you feel that the cultural aspects of your background were taken into account?] No, it didn't matter. There was no cultural background that needed to be handled. […] Because I grew up here so there wasn't much of a cultural issue. […] But my parents are overprotective with me. […] It could be just my parents. But I know there are cultural differences. My parents behave differently with the kids, depending whether it's the boy or the girl. (Parent)

Amongst a number of recurrent themes that arose during our analysis, the idea of culture as being linked with territoriality or space, and by association with place of birth, place of living and nationality, emerged as a dominant theme. As illustrated in the following extracts, some participants also mentioned the culture of a region, a city, or a neighborhood.

[I think culture] can change a few little things. […] In [my father's country of origin], people don't react the same way. (Youth)

It might be because of our culture. […] There are things we don't do in Japan. (Parent)

There was a case presentation that was typically from Verdun [a Montréal neighborhood]. Yes, [it was representative of] the culture of Verdun. (Clinician)

Temporality was present in participants' discourses about culture, such as the idea of cultural differences being attributed to another era or time period and, by association, to another generation. In addition, when issues of ruptures experienced through the passage of time or through displacement and relocation were addressed, participants elaborated on intergenerational cultural differences, interculturality, and on the culture of migration per se, as illustrated here:

As soon as she [my daughter] arrived here, she got piercings, tattoos. At home, in Algeria, it's very rare that we do that. […] Many times we talked about how it's different [culturally] here. […] It's difficult also to have ideas and principles your whole life, and then… […] Maybe with time they [my children] will understand. They will have children and they will see how difficult it is. (Parent)

She [the clinician] understood my family, but she did not understand my grandparents, they are too old. (Youth)

Like most immigrant parents, he [the father] must have a best interest in his children succeeding in this culture and succeeding in this context. (Clinician)

The theme of difference was also central in participants' discourses on culture. Differentiated ways of perceiving, thinking, and acting, linked to differences in collective values, beliefs, mentality, norms, practices, and customs were attributed to culture by participants. Processes of differentiation and of othering were also present in our results. Participants' discourses sometimes presented the idea of "being cultural" as that of "being different". Culture was sometimes understood as belonging to the *other*, and some clinicians from Project II who were members of the ethnocultural majority were taken aback by a question about their own cultural identity. The following extracts exemplify these ideas:

We're not used to be asked about that [our cultural background], as a White person from here. […] I'm from a background that was very White, francophone, with a majority of people coming from France at the time. […] I find my background is very… dull. […] You make me more aware of the notion of the Other with the big O. […] As if I'm the norm and the Other is… (pause) So when you ask me about my cultural identity, I must admit I don't really know what to say. (Clinician)

In my culture, this disease doesn't exist. People would just say: this child is bizarre. This child is crazy. (Parent)

My father [is from another country and he] is more authoritative. But my mother, [she's from here, and] she'll be like: if you want to do it, do it. As long as you don't hurt yourself. (Youth)

In line with this idea of culture as a differentiated way of experiencing the world, some participants attributed to cultural differences the fact that certain situations, attitudes or actions could be felt as incomprehensible, baffling or irrational. The following extracts convey this idea:

Sometimes I feel like sharing with colleagues and say: Listen, I don't understand this community. They did this or that thing. Is this cultural or is it only specific to this family? (Clinician)

We don't have the same culture. We don't have the same manner, with the rules, than Canada. So it's a little hard for them [clinicians] to understand […] why my father reacts like that to certain things. But it's just because it's like that in our culture. (Youth)

Another important theme present in participants' narratives was the idea of "anchoring", whereby a culture provides a sense of belonging to a collective that is linked by identity. Hybridity in cultural identities was also mentioned by a few participants as was the idea that affiliations and identities can be assigned or claimed, and can range from small groups (e.g., a family or a work team) to larger ones such as ethnic groups, religions, linguistic communities or professions. Here are a few examples of this finding:

I have children and they have three cultural identities. I speak French. English, not really, [but my husband does.] And of course, we also hear Spanish at home because my stepmother and my husband, they're really bilingual with Spanish. (Clinician)

At home, we're not religious at all. We're Muslims by identity. But my husband is an atheist. Myself, I believe in God, but I'm not religious. (Parent)

When addressing the question of culture, and especially of cultural identities, certain parts of participants' narratives contained generalizations and stereotypical elements. Oftentimes, these were attributed to members of out-groups, but also sometimes to one of the participant's own cultural affiliations. Negative representations of culture and cultural identities could also be found in participant narratives; for instance, by equating the "cultural other" with the idea of not being "open" or "modern", as illustrated in the extracts below:

[The difficulties during the clinical follow-up] were not really cultural. They [the parents] are very open-minded, and they've been here [in Canada] for a long time. (Clinician)

There wasn't really a cultural gap [between the clinician and my family] because we're quite modern and Canadian. So, we're not really like real Arabs. We have modern ideas and all that. (Youth)

Maybe it's our culture. We are not… let's say affectionate between parents and children. In the sense that… I really like to give hugs to my children, but you don't see that in China. (Parent)

The way authority is perceived is different in certain cultures, some sort of submissiveness, where the expert is the expert, and it's the doctor. […] [This Vietnamese family] wanted the expert. (Clinician)

Finally, it is also worth noting that the narratives of certain participants were filled with nuanced views on culture, evoking its complexity, heterogeneity, and fluidity:

I think [as a clinician working with culturally diverse families], you always need to put yourself into question. Because cultures are not fixed; it changes all the time. And so do we, as people; we change. (Clinician)

I can reject the values that don't really suit me, either the ones from Canada or the ones from Morocco. […] I think cultural diversity is enriching for everyone. (Parent)

I don't mind if you're from a different culture. I think it depends on the way you live it (Youth).

Working with cultural elements: mediating dialogue

In addition to the many different and sometimes contradictory definitions of culture that are present in participants' discourses, our results suggest that the use of the term culture varies and can be situated on a continuum that ranges from *engaging in a dialogical encounter* to *avoiding dialogue*, to *rejecting dialogue*. In some instances, participants would talk about culture by presenting cultural differences as a way to enrich single and narrow perspectives, and as a source of creativity to co-create new meanings and solutions. In one case, a Muslim mother wearing a *hijab* who recently migrated from the Middle East reported that during her family's YMH follow-up, the clinician's attitude was essential in establishing a trustful relationship, especially given the current social context of suspicion in regards to Islam, including certain practices such as wearing the veil. She stated that by her respectful and welcoming attitude, the clinician was able to let her know she was safe with her in a social context where this might not always be the case. This allowed for a climate of cultural safety to be established and for the beginnings of a trustful dialogical relationship to be fostered wherein sensitive issues could be addressed. The following extracts illustrate how culture was sometimes operationalized in participants' discourses as a way to engage in a respectful dialogical encounter:

The clinicians, they really understood me. Because I see they are really unbiased. And they accept our values and things like that, as long as it's for the good of the child. So they don't care if I'm from another culture. […] Wherever you go, you take the good things and you reject the bad ones. So why no learn [from each other]? (Parent)

[Interviewer: Did you feel your way of thinking and of being, culturally, was respected?] Yes, she [my clinician] was never against me or against my opinion with something cultural or norms or values. She never said "this is bad" or something. She just respected everything. […] She was not like… racist or discriminatory or something like that. (Youth)

A lot of professionals that attend Seminars, they have an interesting cultural diversity. And that is very enriching because of this marriage of values, of different ways of doing things… It is incredibly rich. And the beauty of all this lies in the complementarity, in everything one can bring to another in these exchanges, be that related to pitfalls, to values, to customs, to rites, and so forth. […] And there's a climate of trust. We feel that everyone is open and respectful. (Clinician)

On other occasions, research participants would use culture in their discourse as a way to avoid dialogue. In some cases, participants reported instances of "cultural camouflage", which consisted of bringing the cultural dimension to the forefront to protect another aspect of the situation from being recognized and addressed. In other cases, participants reported on instances of feeling stereotyped in their experience of services, while also at times using stereotypes themselves. Therefore, by presenting a fixed, simplified, and essentialized view of oneself or the other, both clinicians or families could avoid taking part in an authentic dialogical encounter; hence, limiting the possibility of transformation. Here are a few illustrations of this operationalization of culture:

People will say, 'You know, in my country, it's like that'. And you realize that you know other people from this country, and it's not like that. [...] So the mother was often using the argument that 'You know in Vietnam, blah blah blah...' And I was finding it hard to accept this kind of argument. (Clinician)

Arabs and Lebanese people, they're emotional, that's all. It's normal. (Youth)

With the Greek mother, we don't talk about emotions. You do something and you move on. It's very engrained in their way of being. (Clinician)

Another use that could be made of culture is that of rejecting dialogue, which negates the value of the cultural other and their perspective. In the extreme, this position could lead to dehumanisation and violence; however, in our study, this usage of culture typically emerged when parents reported incidents where they felt judged or disrespected based on their cultural beliefs, practices, and identities during the clinical follow-up, as expressed in the following extract:

My partner is from Lebanon. His way of raising the children is different than mine, and together we developed a compromise. But the lady [the clinician], she had a way [of seeing things] that she learned or... I don't know. [...] So from the very beginning, I had the impression there was a judgment. (Parent)

Finally, in a similar way as a few parents who expressed feeling judged concerning cultural differences, some clinician participants from Study II expressed the same type of non-dialogue experience; however, in this case, this experience was related to other cultural identities, such as those related to a profession or an organisation, as illustrated below:

I'm the only one from the school milieu [in the Seminars]. I feel a lot of judgment from the other organizations. About us. Against us. Sometimes I think there's a lot of missing information and people are quick to make a judgment. (Clinician)

Discussion

Culture as a situated conceptual montage framing the encounter

Our research results suggest that neither families nor clinicians hold a single, unified, and articulated definition of culture, but rather resort to different and even sometimes contradictory understandings of the notion in their discourses. Multiple conceptualizations of culture coexist and are called upon according to the context and content of the encounter. As such, the notion of culture, as present in our research participants' discourses, tends to take the form of a complex conceptual montage rather than that of a consistent and integrated understanding. This multifaceted understanding of culture was reflected in both clinicians' and families' narratives, which at times could be simplified representations of specific populations, while in other instances conveyed a nuanced and fluid understanding of cultural representations and identities. Typically, a stereotypical utterance would be made on a cultural group and would be followed by the addition of a comment pointing to intra-group variability.

From an anthropological point of view, this conceptual montage of culture includes both outdated and more recent conceptualizations of the notion. In clinicians', parents' and youth's narratives, we can identify the influence of this idea of culture as a "thing" or bounded entity characterized by clear cultural prescriptions and proscriptions which impact

all dimensions of life. This definition of culture as an organizing system or complex whole that is inherited or acquired by all humans as members of a collectivity is salient in participants' discourse. It is also important to note that such a view of culture was more often attributed to the “different other”, especially when cultural elements were considered in an unfavorable light. This use of culture and the othering process it creates is also reminiscent of the hierarchy that was implied in cultural evolutionism, whereby “Western cultures” were considered as the most “advanced” and “civilized” cultures and are now thought of as more “rational”, “open”, and “modern”. One example of this notion is how some participants from cultural minorities would distance themselves from assigned cultural identities in front of external attributions. Additionally, as some participants confided in the interview, to be questioned about one's culture and cultural identity could be experienced as offensive. Our observations also converge with those of Taylor (2007) who noted that *culture* was often considered an impediment to health interventions; however, in our study, the cultural backgrounds that were considered were those of the minority and migrant families and not those of clinicians. This points to the idea of culture as a defensive conceptual tool that can create distance between oneself and the different other when pain, suffering, and powerlessness become overwhelming.

In combination with this reified understanding of culture, our results indicate that a conceptualization of culture as a process of forming representations and meaning making with the role of framing thoughts and actions was also present in participants' discourse. A few participants would hold such a perspective of culture which acknowledges the constant transformation of cultural representations and their political embeddedness. Unsurprisingly, among clinicians this anti-essentialist perspective on culture was adopted by those with a longstanding participation in TIICDSs and years of experience in intercultural care. Some had also previously completed studies in the field of anthropology and had experienced many intercultural encounters in their personal lives. In these instances, culture was operationalized as a means to generate creativity and fruitful exchanges.

In sum, both fixed and dynamic perspectives on culture could be found in a participant's discourse, sometimes even alternating in the same sentence, rather than certain participants holding one view over the other. This sort of come-and-go movement between generalizations and specifications seems to parallel the human ambivalence about the desire to explore the unknown, or to seek refuge in the familiar, as well as the desire to attend to the other's experience or to distance oneself from it and center on the self. This movement also evokes the ambivalence towards the desire for change that an encounter with a “different other” could bring about and the desire for stability that can be ensured by keeping it at bay. Thus, culture in the clinic can be viewed as a double-edged sword, as it can be a way to defensively perpetuate stereotypes and colonial views of the other, while also being a process in which to politically embed notions that can be solicited to mobilize individual and collective modes of expression, as well as to explore the complexity of human nature, and to demystify and uncover oppressions.

Dialogical relationships and transformational practice

The fact that participants resort to a multiplicity of understandings of culture in their discourses cannot be dissociated from another set of findings indicating that culture serves as a narrative strategy to mediate clinical encounters, either by engaging in a dialogic rela-

tionship, or by avoiding or rejecting it. Engaging in a dialogue implies recognizing and negotiating points of sameness and points of difference. It also entails that both patients and clinicians will be impacted by the dialogical encounter (Qureshi, 2005). For interlocutors to engage in a dialogue, and therefore take part in a truly transformative practice, all involved parties must – at the very least – agree to acknowledge the others' perspectives. This minimum requirement of acknowledgement allows the interlocutors to work towards finding a common ground from which they can collectively move forward. As documented in our study, such a decentering and negotiation process can be impacted by contextual elements of the encounter. Illustrations from Study I highlight that clinicians' social and cultural identities can help modulate families' feeling of cultural safety and that these must be looked at on a case-by-case basis, as both proximity and distance between interlocutors' identities can be either desired or feared for a diversity of reasons. During Study I interviews, the importance of the clinician's attitude in establishing a climate of trust for which a dialogical relationship could emerge was often mentioned by parents and youth and was deemed as key in influencing what could be said and addressed in the clinical encounter; thus, creating a fruitful working alliance. When cultural representations and clinical issues are explored respectfully, a hybrid cultural space can be developed, allowing for a creative and transformative practice. Similarly, in Study II, TIICDSs participants from different disciplinary backgrounds and organisational affiliations must try to momentarily withhold their judgments against other theoretical orientations and work environments and negotiate a common understanding of the clinical situation – even if only partially – to decide on an appropriate way to tackle it. This process of collective meaning making that occurs during TIICDSs also reveals the cultural, constructed, and fluid aspects of case formulations, which are neither "expert truths" nor "purely subjective creations". They are situated knowledge that emerged at a specific moment in time, at a specific place, and within a specific set of relationships (Rousseau et al., 2020). Again, this highlights the fact that the context of the elocution of discourses includes multiple levels, not only the dialogical level but also the social, cultural, and political ones.

In light of our results, the use of culture in participants' discourses appears as situational and is focused on *what is at stake* in the encounter when interlocutors resort to it (Kleinman, 1998, p. 360; Ware & Kleinman, 1992, p. 547). In some cases, when cultural elements were presented as fixed in a discourse, it pointed to a defensive narrative strategy to prevent dialogue. This must be contextualized to understand what is at stake in the encounter. When one resorts to cultural camouflage and confuses a situation or symptom with a cultural element presented as consensual, this might indicate a narrative strategy to avoid tackling a sensitive issue that could bring about too much suffering. When one makes use of stereotypes and of culture as a way to essentialize and freeze differences (Abu-Lughod, 1991), then attending to the complexity of individual experience and other layers of reality is deflected and the potential for clinical change is reduced. Cultural differences can be brought to the forefront and be part of both clinical and political resistance during YMH interventions. A parent might wonder: "Why are these changes proposed to me? And what are the possible consequences for my child, for my family, or for my community?" What makes this quite complex is that *what is at stake* encompasses psychological, relational, and sociopolitical processes. It can be very difficult to discern which dimension is mobilized, all the more so as these processes occur both consciously and unconsciously. In our findings, in the absence of cultural safety, participants expressed their fears and lived experiences

of being judged or disrespected due to their outlook of the situation, perhaps even blamed for the issues being addressed. In such instances, families' defensive strategies can take the form of withdrawal and identitarian closure triggered by cultural harm, hence ruling out any possibility of dialogue and giving way to stereotypical and negative representations of the "cultural other". This has serious clinical implications because it can lead to disengagement from the therapeutic process, absence of clinical outcomes, and dissatisfaction with care. Incidentally, the literature in YMH reports an underutilization of services by cultural minority families (Freedenthal, 2007; Kataoka et al., 2002; Yeh et al., 2003). Other findings from our research program also indicated that migrant families show a lesser degree of engagement in the clinical process compared to non-migrant families (Bolduc, 2017).

Aiming at cultural safety to improve quality of care

In light of our research findings, it appears that aiming towards cultural safety in the clinic is a nonlinear work in progress. As reported in their discourses, when clinicians, parents, and youths address cultural differences by resorting to various operationalizations of culture, they go back and forth between avoiding, rejecting, and engaging in a fruitful dialogue with one another. Our results suggest that minority families' experiences of YMH services may be improved with three types of initiatives: (1) raising awareness of the importance of culture in YMH services; (2) supporting training initiatives in intercultural care; and (3) promoting an ongoing reflective practice enabled by a supportive environment.

Acknowledging the salience of culture in YMH interventions may be the first step in making YMH services culturally safe and shifting away from the phenomena of cultural blindness. Raising clinicians' awareness of their own cultural representations is key, as it allows them to use the cultural elements that emerge in the clinic as an opportunity to engage in a respectful and non-judgmental dialogue. It has been proposed that resorting to universalism, or what has been called "minimization strategies", is quite common among mental health professionals (Hammer, 2011). Indeed, as some parents and youths mentioned during the interviews, certain clinicians do not ask questions about culture or cultural differences and are not attuned to the way culture is present in the clinic. This attitude lacks the awareness of *what matters most* and *what is at stake* for families in YMH care and may represent a protective form of avoidance, preventing the engagement in an authentic dialogue. Dialogue, as understood from a Bakhtinian perspective with its emphasis on better understanding rather than consensus, is a major contribution to any positive therapeutic change, especially in YMH (Seikkula & Trimble, 2005). Therefore, the way in which the notion of culture is used in an encounter - that is, the way in which speakers conceptualize culture and refer to it in their discourse - can have the effect of enabling authentic dialogue and transformative practice or of mainly allowing a monological approach. Hence, clinicians need to elicit and navigate both their own avoidance strategies, as well as those for whom they provide care. On the one hand, if avoidance or rejection narratives about culture are employed by a person or family seeking care, then the clinician is responsible for understanding their rationale and purpose in order to gently open up a dialogue. On the other hand, if these discursive strategies are employed by clinicians, this would demonstrate their cultural blindness and their lack of intercultural competence; in this case, this would need to be addressed through appropriate training and supportive work conditions.

The issue of training in intercultural care is very complex, as it implies not only the acquisition of knowledge and skills but also the development of attitudinal competences (Sue et al., 1992). Addressing practitioners' attitudes is a major challenge because it implies exploring the trainees' own cultural representations and identities. Although this can be addressed through direct clinical experience under the supervision of experienced intercultural clinicians, the relative lack of experienced supervisors represents a major obstacle to complying with this training objective, a concern that is particularly visible in YMH care (Rousseau & Guzder, 2015). In Montréal, TIICDSs were implemented to respond to this challenge. Results from an evaluative study indicated that these Seminars could help participants better capture the complexity of the cultural and social experience of the families they meet and decrease the reliance on cultural formulations that essentialize culture (Rousseau et al., 2020). In line with these results, our findings indicate that this training modality can also positively impact clinicians' attitude, as longstanding TIICDSs participants used culture in their narratives mostly to engage in dialogue. Our results indicate that a key aspect of this training modality is for trainees to feel culturally safe, thus facilitating their awareness of their own cultural representations and biases. In addition, parents and youths who were being followed by trained clinicians all mentioned feeling culturally safe in their presence and none of the cases reporting on non-dialogue came from clinicians having attended TIICDSs. This outcome on families' experiences of YMH services supports the implementation and pursuit of such training initiatives to increase cultural safety in care.

Another layer of complexity in intercultural training lies in the difficulty of transmitting both generic and specific types of culturally informed knowledge and skills (Lo & Fung, 2003). In other words, it is difficult to find the right balance between the extremes of "cookbook" approaches to training, which tend to reinforce stereotypes and essentialize culture, and person-centered approaches, which could also be read as "cultural avoidance", meaning telling clinicians to treat service users with empathy and respect is not sufficient when training them to be culturally sensible, safe, and "competent". In line with Fung and Lo (2017)'s work on culturally competent psychotherapy, we consider that various "generic" cultural issues may arise at each phase of YMH follow-ups that can be addressed through open and respectful dialogue, and note that specific cultural knowledge can guide their resolution. Intercultural training can also help clinicians learn how to collect cultural information in a sensitive and respectful way, as well as how to make intervention propositions that can be negotiated and reframed in culturally acceptable ways. Thus, ways to alleviate individuals' and families' suffering can be tackled with countercultural, neutral, culturally congruent or reinforcing approaches (Fung & Lo, 2017).

Finally, it is important to stress that cultural safety also needs to be addressed at the systemic level, as in its absence, professionals can be caught in a double bind between being at odds with their organization and work environment and being at odds with their ethical and professional judgment (Johnson-Lafleur et al., 2019). The sources of support that organizations can offer to their personnel working with culturally diverse populations include adequate access to interpreters, access to intercultural training, additional time for complex interventions, and access to clinical discussions spaces.

Our research results have limitations, which mainly derive from the specificities and fieldwork settings of our studies. First, many interviewees in Study I were clinicians working in culturally diverse neighborhoods for many years, while all participants from Study II were clinicians involved in intercultural training. As such, our research participants are

likely to be more interested in issues of culture than other professionals in the health and social services system, to hold less stereotypes and more nuanced views of culture, and to highly value cultural diversity and social inclusiveness. If the research was to be conducted again in another context, it is likely that the use and understanding of culture by clinicians would be distributed differently on our continuum of dialogue mediation. It is also important to note that the analyzed narratives in our paper are not discourses that emerged *in situ* during clinical encounters but rather in the context of research interviews. This needs to be considered since the presence of researchers has a definite influence over what narratives will be produced and shared by participants. This highlights the importance of establishing a climate of trust and cultural safety not only in clinical practice but also in research; especially, if the goal is to move away from defensiveness, social desirability, and self-silencing of participants, as well as to gain access to other layers of reality. Finally, it is important to note that since we have chosen to unpack the complexity and variability in the understanding and use of the notion of culture, other sources of variability in the participants' discourses are not presented in this article for the sake of brevity, although they would certainly provide additional insight into these issues.

In addition to our study limitations, it has to be said that the cultural safety paradigm also presents limitations. Because it focuses on power, social inequities, and the vulnerabilities of families, the notion of cultural safety puts a lot of emphasis on the possibility for the practitioner to harm (Kirmayer, 2012) and less on the possibility of cultural norms and practices to do so. Also, in a cultural safety paradigm it is the person receiving services that holds the power of determining the success of an intervention (Ramsden, 2002). However, because of a multiplicity of factors, from clinical to relational or political ones, the person receiving care is not always in the best position to define if an intervention was culturally safe or not, although neither is the clinician. A combination of perspectives appears as more promising to reduce biases and to promote equality and shared responsibility in mental health services. Finally, by overemphasizing culture, a focus on cultural safety runs the risk of "fixing" differences, for a diversity of political purposes and orientations, in a similar manner as race used to (Abu-Lughod, 1991). This is why it is imperative to maintain an intersectional and critical approach to cultural safety, as noted by Anderson et al. (2003).

Future research could explore how patients can impact the cultural safety of clinicians and how clinical issues and sociopolitical contexts frame patients' perceptions of cultural safety. It would also be important to study the issue of cultural safety in research. Future studies could examine how researchers' understanding of culture and of cultural safety can influence the formulation of research questions and the development of methodological tools, such as questionnaires and interview guides, which in turn frame participants' narratives, researcher's analyses, and research results. As suggested by our findings, ideological and political agendas are present at every level in clinical practice and research, and they are implicit in the way culture is used. When agendas are guided by a quest for more equity and social justice and less social suffering, then culture is used as a source of joint creativity towards social change. When normalizing forces are at play, culture is used to identify and reduce differences with the intent of assimilating cultural minorities into the majority. However, when othering forces are at play, culture becomes a conceptual tool to exercise power by making other (Abu-Lughod, 1991), by maintaining differences and excluding groups assigned as "cultural"; thus, reinforcing social inequality.

Conclusion

Our research findings indicate that culture is present in research participants' discourse as a complex montage of various implicit definitions. Both clinicians' and families' understandings of culture seem to be influenced by definitions of the concept that existed in different periods of anthropological thought, including early 20th century stereotypical and fixed representations, as well as more recent nuanced, fluid, heterogeneous, politicized, and process-based understandings of culture. Our results also suggest that culture can be used as a narrative strategy to mediate clinical encounters, either by engaging in an authentic dialogue, or by avoiding or rejecting it. Thus, culture as a conceptual tool in the clinical realm can be seen as a double-edged sword, in that it can be used to both reify stereotypes and inequalities, as well as mobilize representations to establish cultural safety and enable transformative practice. Our research results highlight the fact that the context of the production and enunciation of participants' discourses around culture is important and includes multiple dimensions, not only the dialogical one but also the social and political ones. Strategies to improve cultural safety in YMH services need to be addressed at the level of professional practices in terms of clinicians' training and working conditions, both of which stress the importance of involving the organizational and systemic levels.

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