

Chapter 4

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THE RISE OF MULTICULTURALISM IN CLINICAL PSYCHOLOGY

The Diversification of the U.S. Population

Cultural diversity has historically been a hallmark of the U.S. population, but in recent years, the country has become *much* more diverse. The number of people of minority ethnicities, as well as the proportion of the U.S. population they represent,

has increased dramatically. For example, in a single decade (1990–2000), the Asian American/Pacific Islander population and the Latino/Latina/Hispanic population each grew by about 50% (U.S. Census Bureau, 2001). Also, in 2000 there were 28 million first-generation immigrants in the United States, representing about 10% of the entire U.S. population (Martinez, 2004). One in five U.S. schoolchildren speaks a language other than English at home (Roberts, 2004).

In certain parts of the United States, the increasing diversity is even more pronounced. In Miami, for example, Latino/Latina/Hispanic residents represent the majority of the population (U.S. Census Bureau, 2006a). In San Francisco, individuals of Asian descent represent almost one third of the population (U.S. Census Bureau, 2006b). And more than 55% of the populations of Detroit and Washington, D.C. are African American (U.S. Census Bureau, 2006c, 2006d).



Photo 4.1 Cultural diversity is a hallmark of the U.S. population, especially in certain geographical areas. Clinical psychologists are increasingly recognizing the importance of cultural factors in therapy, assessment, and other professional activities.

Clinical psychologists have recognized that the people who might seek their professional services represent a growing variety of cultural backgrounds. As individuals and as a profession, clinical psychologists are making efforts to sensitively and competently address issues of culture. As stated by McGoldrick, Giordano, and Garcia-Preto (2005), “we must incorporate cultural acknowledgment into our theories and into our therapies, so that clients not of the dominant culture will not have to feel lost, displaced, or mystified” (p. 4).

Multiculturalism as the “Fourth Force”

The impact of cultural issues on mental health professionals in recent years has been so extensive that some authors have identified **multiculturalism** as a defining issue of the current era of psychology. For example, Pedersen (1990, 1999) has put forth the argument that in the evolution of the clinical/counseling field, multiculturalism represents the “fourth force.” With this label, multiculturalism is ranked with the three previous movements that have been broadly recognized as dominant paradigms in their respective eras: psychoanalysis as the first force, behaviorism as the second force, and humanism/person-centered psychology as the third force (Bugental, 1964). Multiculturalism, then, stands as a major pervasive influence on the work of contemporary clinical psychologists. It represents a fundamental change of emphasis but one unlike the previous three in terms of its method of impact. Whereas behaviorism and humanism emerged as challenges to the incumbent first force of psychoanalysis, multiculturalism does not necessarily aim to dethrone any of the first three forces. Instead, it enhances and strengthens existing models by infusing them with sensitivity and awareness of how they can be best applied to individuals of various cultural backgrounds (Mio, Barker-Hackett, & Tumambing, 2006).

Recent Professional Efforts to Emphasize Issues of Culture

The profession of clinical psychology has addressed the issue of cultural diversity in many tangible ways.

Journals and Books. A plethora of publications on cultural issues in mental health have appeared in recent years. Scholarly journals in clinical psychology have increasingly included articles on cultural topics, and some psychology journals are devoted entirely to issues of culture. (See Table 4.1 for examples.) In addition, a wide variety of books now offer education and guidance to psychologists working with culturally diverse populations. Some of these books focus on a single population, like *Working With Asian Americans* (Lee, 1997) or *Psychotherapy With Women* (Mirkin, Suyemoto, & Okun, 2005), whereas others compile chapters on many different populations, such as *Ethnicity and Family Therapy* (McGoldrick et al., 2005a) or *Counseling Diverse Populations* (Atkinson & Hackett, 2003). Collectively, these publications represent a wealth of cultural knowledge for contemporary clinical psychologists, and their increasing presence acknowledges the importance of the topic.

Emergence of American Psychological Association Divisions. Within the American Psychological Association, new divisions arise when a subset of members recognize a need to study or examine a specific topic in depth. Among the divisions that have been created most recently, many have focused on cultural issues, including

Table 4.1 Scholarly Journals Relevant to Multicultural Issues in Clinical Psychology

Among others, these journals focus on issues of culture and commonly include articles of clinical relevance.	
<i>Cultural Diversity and Ethnic Minority</i> <i>Hispanic Journal of Behavioral Sciences</i> <i>Journal of Black Psychology</i> <i>Journal of Cross-Cultural Psychology</i> <i>Journal of Cultural Diversity</i>	<i>Journal of Gender, Culture, and Health</i> <i>Journal of Multicultural Counseling and Development</i> <i>Psychoanalysis, Culture, and Society</i> <i>Psychology</i> <i>Psychology of Men and Masculinity</i>
Among others, these journals focus on clinically relevant issues and commonly feature articles emphasizing culture or diversity.	
<i>Clinical Psychology: Science and Practice</i> <i>Counseling Psychologist</i> <i>Journal of Abnormal Psychology</i> <i>Journal of Clinical Psychology</i> <i>Journal of Counseling Psychology</i> <i>Journal of Consulting and Clinical</i>	<i>Journal of Marital and Family Therapy</i> <i>Journal of Mental Health Counseling</i> <i>Professional Psychology: Research and Practice</i> <i>Psychology</i> <i>Psychotherapy: Theory, Research, Practice, Training</i>

- Division 35—Society for the Psychology of Women
- Division 36—Psychology of Religion
- Division 44—Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues
- Division 45—Society for the Study of Ethnic Minority Issues
- Division 51—Society for the Psychological Study of Men and Masculinity

American Psychological Association Ethical Code. Numerous specific standards and principles in the most recent edition of the American Psychological Association (2002) ethical code compel psychologists to work with cultural sensitivity and competence. Their inclusion as standards makes it clear that awareness of diversity issues is a requirement rather than merely an aspiration for ethical psychologists. See Table 4.2 for a list of specific ethical standards and principles that relate to multiculturalism.

American Psychological Association Accreditation Standards. When the American Psychological Association decides whether to give its “seal of approval”—in other words, accreditation—to a graduate program in psychology, multiculturalism is a

Table 4.2 Selected Excerpts From the American Psychological Association's (2002) *Ethical Principles of Psychologists and Code of Conduct* Relating to Multiculturalism

- **Principle E: Respect for People's Rights and Dignity**
Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.
- **Standard 2.01 Boundaries of Competence**
(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.
- **Standard 3.01 Unfair Discrimination**
In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.
- **Standard 9.06 Interpreting Assessment Results**
When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

primary focus. In the most recent edition of the American Psychological Association (2005) standards of accreditation, "Cultural and Individual Differences and Diversity" is one of the eight domains that an educational program must address adequately to be accredited. This requirement applies to doctoral programs, predoctoral internships, and postdoctoral internships seeking accreditation. Specifically, the accreditation standards for doctoral programs list criteria such as (1) including people of diverse backgrounds among students and faculty and (2) educating students about the role of culture in the science and practice of professional psychology.

DSM-IV Efforts Toward Multiculturalism. Revisions to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* included “special efforts . . . to incorporate an awareness that the manual is used in culturally diverse populations” (American Psychiatric Association, 1994, p. xxiv). One such effort is the inclusion of a subsection called “Specific Culture, Age, and Gender Features” in the text describing each disorder. For example, the description of Major Depressive Disorder includes the statement that

in some cultures, depression may be experienced largely in somatic terms, rather than with sadness or guilt. Complaints of “nerves” and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or “imbalance” (in Chinese and Asian cultures), of problems of the “heart” (in Middle Eastern cultures), or of being “heartbroken” (among Hopi) may express the depressive experience. (p. 324)

A second effort toward cultural awareness incorporated into *DSM-IV* is an appendix listing culture-bound syndromes to complement the list of official disorders. **Culture-bound syndromes** are described as categories designed to capture “repetitive, patterned, and troubling” experiences of people within a specific cultural group or society (American Psychiatric Association, 1994, p. 844). The list includes about two dozen categories observed in groups from most parts of the world. Some are described as similar to an official *DSM-IV* disorder, but others bear little resemblance. Examples include *rootwork*, in which hexing, witchcraft, or the evil influence of another person bring forth anxiety and gastrointestinal problems (found in some African American, European American, and Caribbean cultures); *sutso*, in which a frightening event is thought to cause the soul to leave the body, resulting in depressive symptoms (found in some Latino/Latina/Hispanic cultures); and *ghost sickness*, in which a preoccupation with death and those who have died elicits a wide variety of psychological and physically debilitating symptoms (found in some Native American tribes). Although some authors (McGoldrick et al., 2005b) have pointed out that a few of the official disorders included in *DSM-IV* might in fact be better described as culturally bound to U.S. or North American cultures (anorexia nervosa, for example, as discussed in Chapter 7), the list of culture-bound syndromes in the *DSM* nonetheless signifies an increase in the profession’s recognition of multicultural issues.

Revisions of Prominent Assessment Methods. Several prominent assessment tools used by clinical psychologists have been revised in recent years with the specific intent of making them more culturally appropriate and serviceable. The Minnesota Multiphasic Personality Inventory (MMPI), an especially popular and well-respected personality test, underwent a major overhaul in the 1980s, resulting in the publication of the MMPI-2 in 1989. Compared with the original MMPI, the

normative scores for the MMPI-2 were based on population samples that were much more representative of the cultural diversity of the U.S. population (Nichols, 2001). (Chapter 10 includes much more information on the MMPI and MMPI-2.) Other examples include the adult and child versions of the Wechsler tests of intelligence (e.g., Wechsler Adult Intelligence Scale, Wechsler Intelligence Scale for Children), which are among the most widely used and highly esteemed in their respective categories. As these tests have been revised in recent years, their authors have made efforts to create instruments that minimize cultural bias and maximize cultural inclusion (Flanagan & Kaufman, 2004). (Chapter 9 includes much more information on the Wechsler tests.)

CULTURAL COMPETENCE

What Is Cultural Competence?

Clinical psychologists should strive for **cultural competence**, but what exactly does it involve? When principles of cultural competence are applied to counseling or therapy, the more specific term *multicultural counseling competence* may be applicable

Multicultural counseling competence is defined as the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society . . . and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (Sue & Sue, 2003, p. 21)

A key phrase in the definition above is "awareness, knowledge, and skills." As described by Sue and Sue (2003), these are the three primary components to multicultural competence as applied to clinical/counseling work. Let's examine each one in detail.

Cultural Self-Awareness

Cultural competence begins with learning about one's own culture—not only the basic facts such as where one's parents or ancestors came from but also the values, assumptions, and biases that one has developed as a result of all cultural influences. When a clinical psychologist attains **cultural self-awareness**—that is, comes to understand that his or her viewpoint is (like everyone's) unique and idiosyncratic—several conclusions are within reach. For example, the psychologist may adopt a viewpoint toward clients that is less egocentric and more appreciative of the varying experiences of life. Also, the psychologist may come to recognize that differences

between people are not necessarily deficiencies, especially if the difference demonstrated by the client is common or valued in his or her own cultural group.

Of course, the process of cultural self-awareness can be difficult or unpleasant for psychologists, because it may require admitting and coming to terms with some undesirable “isms”—racism, sexism, heterosexism, classism, or similar prejudicial or discriminatory belief systems that we’d rather pretend we didn’t have. But by examining them and exposing them to ourselves, we can take steps toward minimizing them and the negative impact they might have on our clients.



Photo 4.2 Cultural self-awareness, or an appreciation of the clinical psychologist’s own unique cultural viewpoint, is a key element of cultural competence.

Knowledge of Diverse Cultures

To know one’s own culture is a good first step, but it won’t amount to much, unless the psychologist also possesses information about the client’s cultural groups. Simply put, the psychologist should know the client’s culture. Efforts in this direction should be continual—learning through reading, direct experiences, relationships with people in various cultures, and other means. This knowledge should include not only the current lifestyle of the members of the culture but also the group’s history, especially regarding major social and political issues. Of course, therapists can’t know everything about every culture that might be represented by a client in a country as diverse as the United States. In fact, acknowledging cultural differences with clients is typically a good idea, and asking a client to explain the meaning or importance of a particular experience from his or her point of view can ensure a more culturally sensitive

understanding. But clients shouldn't bear too much of the burden of educating the psychologist; instead, the psychologist should aim to enter each session with sufficient knowledge of the client's cultural background.

Of course, the psychologist should not assume that every individual is typical of his or her cultural group. In other words, although a cultural group may have a collective tendency, its individual members may vary greatly from that tendency. To assume that a member of a cultural group will exhibit all of the characteristics common to that group is to prejudge. The individual would be better served by a psychologist who appreciates the cultural group norms but who also appreciates the **heterogeneity** inherent in every culture. See Box 4.1 for further discussion of heterogeneity within a culture.

••• Box 4.1 Metaphorically Speaking •••••

If You've Seen Yao Ming, You Understand Heterogeneity Within a Culture

The average height of a Chinese man is about 5 ft 7 in.—about 2 to 3 in. shorter than the average height of men from the United States. So if you are a clinical psychologist and you know that the new client in your waiting room is a Chinese man, you might expect to see someone around 5 ft 7 in. tall. But when you open the waiting room door and Yao Ming stands up—all 7 ft 6 in. of him—you understand right away that your client is a huge exception to the rule.



Photo 4.3 Yao Ming's extraordinary height illustrates that the characteristics of an individual do not necessarily follow cultural trends. Regarding their clients' psychological characteristics, culturally competent clinical psychologists appreciate the exceptions as well as the rules.

Yao Ming is a Chinese man and a star basketball player in the NBA. His height illustrates a powerful lesson about cultural sensitivity—although members of a culture as a *group* may tend toward certain norms, any *individual* within that group may fall far from that norm. Clinical psychologists should aspire to understand the norms of the cultures with whom they work, but if they rigidly assume that every person in that culture fits those norms, they are guilty of unfair and often inaccurate prejudice. To some extent, generalizing is inevitable when discussing cultural groups (McGoldrick

et al., 2005a), but our generalizations should be “guidelines for our behaviors, to be tentatively applied in new situations, and they should be open to change and challenge. It is exactly at this stage that generalizations remain generalizations or become stereotypes” (Sue & Sue, 2003, pp. 119–120).

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Actually, your statistics course probably included some basic concepts that can help illustrate this point: measures of central tendency, such as the mean, and measures of variability, such as range or standard deviation. Any group of numbers will yield a mean, but a quick glance at the scatterplot shows that there is some variation around that mean, and in some cases, the outliers are quite extreme. The client in the psychologist's office represents one of those points on the scatterplot, and although it is important to appreciate the important central tendencies of that group, it is equally important to recall that the client might be an outlier.

Consider another central tendency of Chinese and many other Asian cultures—the emphasis on collectivism over individualism. In contrast to the tendencies in European American cultures, members of Asian cultures tend to value the welfare of the family or group over their own welfare as an individual. Numerous authors on the subject have indicated that members of Asian cultures assign great significance to harmony, interdependence, respect, and loyalty in close relationships, and they will often forgo individual self-directed accomplishments as a result (e.g., Dana, 1993; Lee & Mock, 2005; Shibusawa, 2005). It is important for a clinical psychologist to be aware of this tendency toward collectivism among Asians, but any particular client may be an exception to the rule, and the clinical psychologist must be open to this possibility as well. Just as Yao Ming stands almost 2 ft higher than the average Chinese man, the Chinese client in the waiting room may hold very individualistic—rather than collectivistic—values. Although this client's status as a cultural outlier is less obviously visible than Yao Ming's height, it is nonetheless the responsibility of the clinical psychologist to be perceptive and responsive to the existence of such atypical cultural members.

Culturally Appropriate Clinical Skills

Once the psychologist has attained cultural knowledge of self and clients, the next step is to develop suitable strategies for assessment and treatment. In other words, the approaches and techniques that a psychologist uses to improve a client's life should be consistent with the values and life experience of that client. "Talk therapy" may work well for many, but for some cultural groups it may be a bad fit. Similarly, clients from some cultures may place great value on "insight" into their psychological problems obtained over many months, but clients from other cultures may respond much more positively to action-oriented therapies with a short-term focus. Other common features of traditional psychotherapy, including verbal self-disclosure of personal problems and 50-minute sessions in an office building, may not be entirely compatible with clients from certain cultural backgrounds.

ARE WE ALL ALIKE? OR ALL DIFFERENT?

The discussion of cultural issues brings up some important, fundamental questions about human beings that are applicable to psychologists and the clients they see. To what extent are all people—and the experiences and problems they bring to therapy—similar? And to what extent might they differ from one another?

Etic Versus Emic Perspective

Dana (1993) describes two distinct perspectives that psychologists have used during the history of the profession. The first, known as the **etic** perspective, emphasizes the similarities between all people. It assumes universality among all people and generally does not attach importance to differences between cultural groups. This perspective was more dominant in the early days of psychology, when most of the people teaching and practicing psychology were male, of European descent, and of middle-class or higher socioeconomic standing. Generally, their viewpoint was put forth as the normative viewpoint on such issues as defining psychological health, identifying and labeling psychological disorders, and developing therapy approaches.

The **emic** perspective differs from the etic perspective in that it recognizes and emphasizes culture-specific norms. A psychologist employing the emic perspective—which has grown in prominence along with the rise in multiculturalism—considers a client's behaviors, thoughts, and feelings within the context of the client's own culture rather than imposing norms of another culture onto the client. Compared with the etic perspective, the emic perspective allows psychologists more opportunity to appreciate and understand how the client might be viewed by members of their own cultural group. In short, the emic approach stresses that individuals from various cultural groups “must be understood on their own terms” (Dana, 1993, p. 21).

As a sidenote, Dana (1993) mentions that the terms *etic* and *emic* were derived from the field of linguistics and from the terms *phonetic* and *phonemic* specifically. Historically, linguists have used the term *phonetics* for sounds that are common to all languages and the term *phonemics* for sounds that are specific to a particular language (Dana, 1993; Pike, 1967). The distinction between the two terms—*universality* versus *culture specificity*—remains in the way the terms *etic* and *emic* are currently used in psychology.

Tripartite Model of Personal Identity

If the etic and emic perspectives represent two opposite viewpoints, perhaps it would be beneficial to consider a continuum that includes not only these two

extremes but also some middle ground. Sue and Sue (2003) offer a three-level model called the **tripartite model of personal identity** in which all levels hold some degree of importance.

One level in this model is the **individual level**. Here, the premise is that “all individuals are, in some respects, like no other individuals.” A second level is the **group level**, where the premise is that “all individuals are, in some respects, like some other individuals.” The final level is the **universal level**, based on the premise that “all individuals are, in some respects, like all other individuals” (Sue & Sue, 2003, p. 12). A psychologist who can appreciate a client on all three levels will be able to recognize characteristics that are entirely unique to the client, others that are common within the client’s cultural group, and still others that are common to everyone. Sue and Sue (2003) argue that appreciation of all three levels is indeed the goal, but that the group level has been overlooked traditionally in psychology, especially when the group is a minority culture, so psychologists may need to make more deliberate efforts in that direction. See Figure 4.1 for a visual representation of the tripartite model of personal identity.

WHAT CONSTITUTES A CULTURE?

When someone inquires about your own cultural background, which of your characteristics come to mind? Many would list their race and ethnicity, and some others would include a multitude of additional characteristics. If clinical psychologists are to function in a culturally competent and sensitive way, it makes sense to consider what exactly we refer to when we say “culture.”

Narrow Versus Broad Definitions

Those who argue for a more narrow definition of culture typically point to ethnicity and race as the defining cultural characteristics. Indeed, many books and articles on the topic of culture focus exclusively on issues of race or ethnicity. According to some who endorse this perspective, the inclusion of other variables as “cultural” would unfairly de-emphasize the socially, politically, and personally important characteristics of race and ethnicity (Mio et al., 2006).

On the other hand, some argue that culture can be defined by a much broader range of variables, including “any and all potentially salient ethnographic, demographic, status, or affiliation identities” (Pedersen, 1999, p. 3), or that culture can be composed of “any group that shares a theme or issues(s)” (Sue, Ivey, & Pedersen, 1996, p. 16). Others have stated that ethnicity may be the primary determinant of culture but not the only one: further factors can include

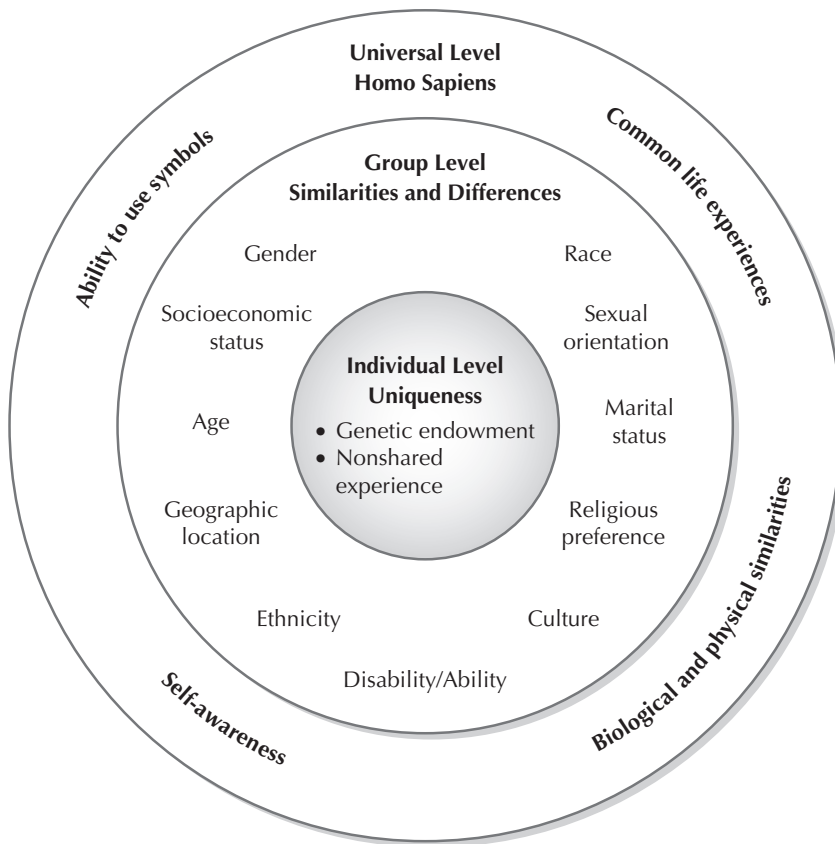


Figure 4.1 Tripartite Model of Personal Identity

SOURCE: From *Counseling the Culturally Diverse*, 4th edition, by Sue, D. W., & Sue, D. Copyright © 2003, reprinted with permission of John Wiley & Sons, Inc.

socioeconomic status, religion, gender, race, geography/region, age, sexual orientation, and political affiliation (McGoldrick et al., 2005a).

Whether or not the characteristics beyond race and ethnicity are universally accepted as components of culture per se, quite a few books, chapters, and articles have been written with the intent of making psychotherapists and counselors more sensitive to these characteristics. For example, therapists can educate themselves about gay clients (Israel, 2003), disabled clients (Kosciulek, 2003), elderly clients (Qualls, 2003), low-income clients (Acosta, Yamamoto, & Evans, 1982), Appalachian clients (Harper, 1996), orthodox Jewish clients (Mirkin & Okun, 2005), and many, many other specific groups whose defining characteristic is neither race nor ethnicity.



Photo 4.4 In your opinion, what variables should clinical psychologists consider when they appreciate their clients' cultural backgrounds?

Additionally, there are some subsections of society—**subcultures**, if you will—that may be especially relevant for certain clients. As an example, consider a psychologist working in a prison setting or with a former prison inmate who was recently released. If there is such a thing as “prison culture”—a shared lifestyle with its own unique norms, expectations, values, and so on—it would probably be wise for the psychologist to consider it in addition to such variables as race, ethnicity, gender, and others. Likewise, a psychologist working with military personnel should have some appreciation of how military culture differs from civilian culture. Many other “subcultures” based on specific work settings, living communities, or other variables may represent major or minor influences on the life experiences of a client (Arredondo et al., 1996).

Interacting Cultural Variables

When we consider how many variables might contribute to culture, it's hard to avoid the conclusion that for any individual with whom a psychologist works, culture might be multifactorial. In other words, lots of cultural variables may interact in unique ways to shape the life experience of a client. Of course, ethnicity and race may be most important for certain clients. But other variables might play significant roles as well.

Consider, for example, Esteban and Maria, two clients who share similar Latino/Latina/Hispanic ethnic backgrounds. In the spirit of cultural competence, their respective therapists should appreciate their ethnicity, but perhaps the cultural considerations should incorporate other factors as well. If Esteban is a 28-year-old gay man living an upper-middle-class life in Los Angeles, while Maria is a 66-year-old heterosexual woman living a lower-class life in a small town in rural West Virginia, the cultures of their day-to-day lives are probably quite different in spite of similar ethnic heritage. Indeed, if they visited each other's homes, they might find themselves living in very different worlds. Culturally competent therapists would certainly appreciate their ethnicity, but such therapists would also consider the way that other variables in their lives interact with their ethnicity to create a unique set of cultural circumstances (Arredondo et al., 1996).

TRAINING PSYCHOLOGISTS IN CULTURAL ISSUES

With the increasing emphasis on multiculturalism in clinical psychology has come an increased responsibility to train psychologists to become culturally sensitive and competent. Graduate program directors, professors, and providers of continuing education share this challenge.

Educational Alternatives

What are the best methods for training clinical psychologists in multicultural issues? Graduate programs have tried a variety of approaches. Often, graduate programs include one or more courses specifically designed to address culture. In addition, some graduate programs may weave cultural training into all of the educational experiences of the graduate student. Courses in psychotherapy, assessment, and research, as well as practicum training, can be designed to incorporate issues of culture. This way, issues of culture are not considered a specialized topic to be examined in isolation but a factor relevant to all professional activities of the clinical psychologist.

Another less traditional approach to training in cultural issues emphasizes real-world experience with individuals of diverse cultures. Supporters of this approach contend that reading about a different culture in a book, or discussing a different culture in class, is no substitute from immersing oneself in that culture to some extent. Thus, through experiences that are professional (such as clinical work or research projects incorporating diverse clients, participants, colleagues, or supervisors) or personal in nature, some training programs promote learning about cultural groups by interacting directly with their members (Center for Multicultural Human Services [CMHS], 2006; Magyar-Moe et al., 2005).

No single “best method” or consensus has emerged for training psychologists to be culturally competent. However, leaders in this field have begun to identify essential components for graduate training programs. For example, Foad and Arredondo (2006, as cited in Fouad, 2006) identify seven specific “critical elements of a multi-culturally infused psychology curriculum” that they believe will improve psychologists working as practitioners, teachers, or researchers. According to these authors (adapted from Foad, 2006, pp. 7–9), graduate training programs should

1. explicitly state a commitment to diversity;
2. actively make an effort to recruit graduate students from diverse populations;
3. actively make an effort to recruit and retain a diverse faculty;
4. make efforts to make the admissions process fair and equitable;
5. ensure that students gain awareness of their own cultural values and biases, knowledge of other groups, and skills to work with diverse populations;
6. examine all courses for an infusion of a culture-centered approach throughout the curriculum; and
7. evaluate students on their cultural competence on a regular basis.

Regardless of the methods used to train clinical psychologists to be culturally competent, an essential ingredient is that the psychologist (or trainee) reaches a deeper appreciation of his or her own cultural identity. Hardy and Laszloffy (1992) describe numerous ways in which self-knowledge can be examined during training, such as in-class discussions, in-class presentations, self-guided assignments, and assigned discussions with one’s own family of origin. In the end, the ability to relate to clients of diverse cultures may depend not only on information obtained through courses and assignments but also on an attitude of “respect, curiosity, and especially humility” (McGoldrick et al., 2005b, p. 6).

Measuring the Outcome of Culture-Based Training Efforts

Let us not forget that psychology is a science, and as such we take a keen interest in measuring the outcome of our efforts to increase cultural sensitivity and competence of psychologists. But consider some of the difficult methodological questions:

- How should we reliably and validly measure the outcome of culture-based training efforts?
- How can we reliably and validly establish a baseline for the level of cultural competence of a psychologist or trainee before the training takes place?

- When we assess the cultural competence component of psychotherapy, whose opinion should we seek? The client? The psychologist? The supervisor? Another interested party?
- How can we make a causal connection between particular culture-based training efforts and particular outcomes? How can we be sure that confounding or unexamined variables aren't responsible for the outcomes we observe?

At the moment, measuring the outcome of culture-based efforts is at a very early stage of empirical investigation, as researchers grapple with issues such as those suggested by the questions above. There is some evidence to suggest that psychologists are learning the ideals of cultural competence but are not always implementing them as often or as comprehensively as they know they should. In other words, there may be a gap between what psychologists “practice” and what they “preach” regarding multicultural competence (Hansen et al., 2006).

On a more positive note, efforts promoting multiculturalism are clearly resulting in some needed improvements related to clinical and research activities of clinical psychologists. In 2003, Sue and Sue lamented the fact that evidence-based treatments (EBTs) very rarely incorporate significant numbers of minority clients in their research trials, so despite the growing number of EBTs, these treatments may not be applicable to diverse populations. Only 2 years later, however, Munoz and Mendelson (2005) provided one of the first reports of a study attempting to establish empirical evidence for a treatment with a specific minority population. This report outlined the development and empirical evaluation of prevention and treatment manuals for depression and other mental health problems designed for San Francisco's low-income ethnic minority populations at San Francisco General Hospital. The authors noted many promising evaluations of these culture-specific manuals, and concluded that “certain psychological theories describe universal aspects of human behavior and can thus profitably inform core therapeutic strategies. However, the effective clinical application of such strategies requires group-specific knowledge and cultural adaptation to increase the likelihood of positive outcomes” (Munoz & Mendelson, 2005, p. 797). Other recent articles (e.g., Barrera & Castro, 2006; Lau, 2006) have significantly advanced the efforts to adapt evidence-based practices for specific cultural groups.

AN EXAMPLE OF CULTURE INFLUENCING THE CLINICAL CONTEXT: THE PARENT-CHILD RELATIONSHIP

Let's consider the cultural issues related to a specific aspect of clients' lives that might be involved in the assessment or treatment of a wide variety of individuals and families: the relationship between parents and their children. Perhaps the first thing that the psychologist should recall is that his or her own expectations



Photo 4.5 The parent-child relationship is a particular aspect of many clients' lives that can differ across cultures.

regarding parent-child relationships are probably influenced by his or her own culture and that those expectations don't hold true for everyone. For example, in some cultures (e.g., British), parenting that produces a child who grows up, moves out, and lives an independent life is usually considered successful. But families of other cultural backgrounds (e.g., Italians) usually prefer that their children stay geographically and emotionally close even after they reach adulthood. Some cultures (e.g., Chinese) tend to insist that children obey parental authority without discussion or negotiation. But families of other cultural backgrounds (e.g., Jewish) tend to create a home life in which open discussion of feelings, including children disagreeing or arguing with parents, is tolerated or even encouraged (McGoldrick et al., 2005a).

It is essential that the clinical psychologist seeing an individual or family such as those described above attain the multicultural competence to consider these varying norms and implement a form of treatment that is consistent with them. Especially in the United States, where diversity is extensive and on the rise, clinical psychologists are likely to work with clients from a wide variety of backgrounds. And as in this example, the cultural issue may serve as a backdrop to any number of presenting problems, including mood disorders, disruptive behavior disorders, relationship problems, and many others. A culturally sensitive appreciation of the Italian family, for example, might include exploration of parents' depressive feelings about a 25-year-old daughter whose successful career has

served to separate her from them. But if the family was British, an exploration of depressive feelings in the parents might strike the clients as off the mark. Similarly, if an 11-year-old boy had a heated argument with his parents because he didn't want to take the piano lessons that his parents had arranged, a culturally sentient response might depend upon whether the family was Chinese, Jewish, or of another cultural background.

CHAPTER SUMMARY

As the U.S. population has become increasingly diverse, multiculturalism has risen to prominence in clinical psychology. Evidence of its growing influence include books and articles on multiculturalism; revisions to the *DSM*, including the inclusion of culture-bound syndromes; the creation of culturally relevant American Psychological Association divisions; and the addition of ethical standards directly related to culture. Cultural competence, for which all clinical psychologists should strive, involves cultural self-awareness, knowledge of diverse cultures, and culturally appropriate clinical skills. Knowledge of cultural norms should be accompanied by an appreciation of the heterogeneity of that culture and the likelihood that an individual may vary from some cultural norms. The tripartite model of personal identity suggests that an individual can be understood as an entirely unique person, similar to members of a cultural group, or similar to all human beings. Cultures are often defined by ethnicity, but numerous other variables may also constitute culture, such as gender, religion, socioeconomic status, age, and sexual orientation. Training efforts intended to increase cultural sensitivity and competence among clinical psychologists and trainees include traditional coursework as well as direct interaction with members of diverse cultures.

KEY TERMS

cultural competence	culture-bound syndromes
cultural diversity	emic
cultural self-awareness	etic

individual level

multiculturalism

subcultures

tripartite model of personal
identity

universal level

CRITICAL THINKING QUESTIONS

1. In your opinion, how important is the issue of cultural self-awareness to clinical psychologists? What is the best way to increase cultural self-awareness among current members of the profession?
2. In your opinion, which level of the tripartite model of personal identity (individual level, group level, or universal level) is most important in the conceptualization of clients?
3. What are the pros and cons of defining culture in a narrow versus broad way?
4. If you were a client, how important would it be to you that your clinical psychologist had received training in cultural issues? Which methods of training would you expect to contribute most to your clinical psychologist's cultural competence?
5. Considering the discussion in Box 4.1 about heterogeneity within a culture, can you think of a cultural group to which you belong but within which you represent an exception to a cultural tendency?