Preface

Following the lead of the American Psychological Association Ethical Code (2002) principles A, D, and E (i.e., do no harm, provide services of equal quality to everyone, and respect others' rights and dignity), Fouad and Arredondo (2007) examined what is needed for psychologists to become culturally oriented and ultimately culturally competent as practitioners, educators, researchers, and organizational change agents. Competency requires evaluating and understanding personal biases and cultural identity as well as the ability to function effectively in cross-cultural interactions. These authors suggest that only a transformed profession can meet these objectives.

This book provides one feasible blueprint for transforming professional training to meet these cultural competency objectives. This book poses the question: How can the existing professional disciplines in the United States and internationally work together to confront common human problems of a magnitude comparable to the imminent threats of nuclear disaster, climate change, and warfare? These threats are fueled by attachment to a precarious status quo, lethargy, a sense of entitlement, pervasive greed, and indifference to human suffering. A relatively small number of affluent individuals now exercise the power to potentially control the human destinies and well-being of everyone else within a global society. Only an informed and collaborative responsiveness within a social justice aegis can transform educational imperatives and redefine social service delivery systems to address the human faces of globalization in a multicultural international society. This book mobilizes contemporary behavioral health conceptualizations of cultural competence training/multicultural education as a basis for practice with existing and emerging at-risk populations.

Thus, the focus of this book is on education and training for professional practice in the United States as a multicultural society. This new society is preoccupied with economic issues while the professional disciplines are self-preoccupied with internal problems relevant to their own objectives and prosperity. These problems inhibit interprofessional communication and cooperative activities, dampen public awareness of disparities in services, and restrict easy access to profession-specific behavioral health resources for all multicultural populations. The United States and

Europe provide exemplars with common problems of professional encapsulation and preoccupation with parochial scientific visions. By showcasing these problems and emphasizing the range of potential training resources, readers are invited to share the excitement of transition from monocultural to multicultural perspectives and from national to global opportunities to foster socially responsible nations predicated on democratic principles.

Chapter 1 describes the human faces of globalization with historic existing and new emerging populations. These burgeoning populations – resident minorities, an impoverished underclass, migrant laborers, refugees, and transnational elite sojourners – are at-risk for unique behavioral health psychopathologies, culture-bound syndromes, problems-in-living, language/acculturation issues, identity transformations, and effects of incursions on their humanity. As these multicultural populations achieve critical mass in host countries, they confront and adapt to changing social policies impacting "welcome," affecting acculturation outcomes, and contributing to societal cohesion or dysfunction. These outcomes of acculturation determine the goodness-of-fit of these new populations with majority populations and either foster or impair opportunities for creating productive and satisfying lives. These outcomes have been reported in an international study of ethnic cultural youth conducted in a number of countries. Understanding the differential effects of acculturation in host countries can potentially inform social policy and diminish or prevent unrest and conflict that can lead to societal upheaval by civil disobedience, warfare, and genocide. Although these are high stakes issues for host countries during this new millennium, there is insufficient political awareness in many of these societies that their systems of professional education can create the knowledge and the skills to accommodate these new and emergent populations in ways that are healthful for both individuals and their societies.

Chapter 2 considers the impact of globalization and psychological science on the human problems within each of these existing and emergent at-risk populations. There are major differences in these problems across these populations and in the available national health/well-being or organizational coping resources. For example, transnational elite, migrant labor, and refugee populations bring their culture-specific idioms of distress with them into host societies that lack the developed resources to recognize, address, or resolve these problems. An impoverished underclass requires social care that creates improved health and educational status, and inculcates hope that these new opportunities can lead toward a better life, particularly for children. Unfortunately, these opportunities are infrequently provided unequivocally by governments even in affluent societies like the United States. For example, the New Orleans underclass was neglected, scattered, and abandoned in the aftermath of a natural disaster. In many countries, the underclass receives primary help from NGOs such as Doctors or Engineers without Borders instead of the government. Organizational resources are available primarily for the transnational elite in the form of international GLOBE and Cultural Hybridization research activities that map cultural influences on occupational stressors. These services have been forthcoming because nations and organizations comprehend and manage manifest and hidden distress differentially.

Chapter 3 provides a detailed description of the professional behavioral health resources within psychology, social work, nursing, psychiatry, and medicine in the United States. For each professional discipline, basic scientific premises and activities are examined within a context of racial/ethnic minority and gender representation. These disciplines occupy different positions on dimensions of science, critical membership ratios for minorities and gender, and especially on the extent of transition from monocultural to multicultural perspectives. Each discipline differs in openness to consider cross-cultural influences for developing ideas, practices, and working alliances internationally. These issues affect the extent and intensity of global commitments to transform professional education that includes new and underserved populations and contributes to the development of consensual training and practice standards.

Chapter 4 explores the history and process of integrating psychological science with professional practice. In the United States, portions of European science advocating general laws of human behavior and professional commitment to the experimental method and quantitative research were imported to document prevailing attitudes toward racial/cultural minorities. In turn, this science was exported internationally, often contrasting with distinctive cultural elements in indigenous or eclectic psychologies. As a result, a focus on human similarities resulted in ethnocentric monoculturalism and what has been characterized as cultural oppression. This limited vision of science replaced earlier humanistic and normative ideologies undergirding the reality perceptions of psychologists with an exclusive normative ideology. For many years this ideology provided a good fit between students and the prevailing monocultural science in the United States. The recent transition toward an emerging multicultural perspective, particularly in counseling psychology, encourages a renewed interest in measuring these ideologies and reexamining student attributes for multicultural education. A broader base of ideologies among students and practitioners provides an important avenue for integrating science and practice.

Chapter 5 describes transitions in psychotherapy, clinical diagnosis, and assessment incorporating cultural sensitivity/therapeutic alliance and contributing to competent professional practice with multicultural populations in these arenas. During the last 10 years, although culturally sensitive training has been available primarily to White psychologists, their therapeutic practices with multicultural clients have frequently been devoid of cultural empathy. This deficit may partially explain the continuing dearth of accessible and relevant treatment services for these populations. Similarly, the token incorporation of cultural considerations in the current DSM has not appreciably diminished over- and under-pathologizing racial/ethnic minorities by diagnosticians. A multicultural DSM perspective increasingly desired by some psychiatrists and other professional diagnosticians classifies racism as a source of psychological trauma, recognizes cultural factors in symptoms and illness experience, and separates pathological conditions from problems-in-living. Finally, this chapter addresses the necessity of holistic health and acculturation status assessment objectives in addition to psychopathology. Holistic health assessment of core human functions, resiliency, strengths, subjective well-being, and salutogenesis is now mandatory to adequately describe the needs of at-risk populations. These

instruments are consistent with the practice of positive psychology emphasizing human assets within a recovery system of care. Adequate training for these comprehensive assessment objectives can positively impact the quality of services and social care for both resident and new multicultural populations.

Chapter 6 recognizes that changes in these practice arenas necessitate major alterations in the contents, structure, and training modalities required for professional competency. These alterations necessitate a revision or expansion of the triadic training model to four factors in order to recognize multiple identity statuses including disability, poverty, age, sexual orientation, and gender. The mainstream Cube Model of Professional Competency provides for interaction of foundational and functional domains associated with different developmental stages. These competency domains include scientific knowledge/methods, individual and cultural diversity, reflective practice/self-assessment, and relationships. The cultural diversity domain was insufficiently elaborated during the conference developing the Cube Model. A new training model, predicated on the Cube Model individual and cultural diversity domain, is proposed in Chap. 10. This model includes personal clinician attributes/demographics, constructs, training modalities, and outcome evaluations. In the context of relaxed and revised APA accreditation standards, two recent program applications are described that contain ingredients for safe, supportive learning environments.

Chapter 7 provides an informed contemporary critique of the scientific adequacy of theory and empirical cultural competency research. This critique leads to an articulate proposal for validation of the cultural competency construct and pursing the development of good ethnic science as a basis for culturally competent training and practice. Experimental and nonexperimental methodologies can be used to establish causality in order to more adequately understand the complexity of the cultural competency construct. However, professional psychology is weak in methodological sophistication and has been slow in responding to potential contributions of theory and method from a variety of other domains including cross-cultural psychology, cultural psychology, and evaluation research. Although a number of personality traits predictive of intercultural effectiveness have been identified and examined by psychometrically sound and cross-culturally valid instruments, there is no consensus on the numbers, range, or importance of these traits. There is also scant research knowledge concerning the spectrum of necessary training ingredients or the effectiveness of current training procedures. Research to identify specific skills for communication and competency with the new at-risk populations as well as established resident multicultural populations is sorely needed.

Chapter 8 presents cultural competency as a byproduct of empirical knowledge and wisdom with a variety of definitions in nursing, medicine, public health, psychology, and social work. In fact, cultural competency is unabashedly called an "art" to emphasize conceptual limitations. A broad definition of cultural competency recognizes organizational and policy levels in addition to practitioners skills. Cultural identity is understood as fluid, complex, and layered, including intersecting and interactive identity components. Critical themes recognize culturally relevant strengths, understanding clinician–client differences and the necessity for

normalizing power differentials. Implementing these themes in multicultural education legitimizes criticism of the existing social order and its institutions in the United States. These themes also provide an educational forum for questioning the viability of contemporary capitalism and its pervasive role in economic globalization.

The term "insurgent multiculturalism" is invoked to describe the role of power in agencies and institutions that fosters acquisition and retention of resources by the privileged while others are denied these resources during their lifetime and across generations. "Insurgent multiculturalism" reaffirms the continuing presence of a monocultural perspective in the United States. As an immediate professional consequence, social justice education has become an essential educational ingredient in preparation for clinical practice within democratic societies. A social justice rationale or social–political context for training provides a sustained educational opportunity to examine the effects of power and privilege on students and ultimately on everyone including clients. These discussions with students confront and explore personal values, attitudes, and self-understanding and are genuine sources of discomfort and distress.

As a consequence, cultural safety is necessary for all students and is now beginning to be considered in professional programs with relatively larger numbers of diverse students. Cultural safety respects client culture by recognizing that incorporating cultural issues in treatment is also necessary to validate the life experiences of clients. By failing to foster a safe therapeutic milieu, therapists may unwittingly impose dominant society values on their clients and define their cultural differences as pathological. In the absence of client expectations for cultural safety, it is not surprising that individuals in various racial/ethnic groups anticipate little succor from available behavioral health services. Client perceptions of cultural safety and clinician competency have not been examined within a context of client retention and clinical outcomes. This chapter recognizes that cultural competency permeates all phases of the curriculum. Furthermore, an organizational climate for education epitomizes trust and openness to evaluation and change by encouraging questioning, conflict, and conflict resolution. This ongoing process contributes a dialogue in which students, faculty, programs, and institutions share responsibilities and power as preparation for practice that mirrors and embodies this training.

Chapter 9 approaches cultural competency by examining the core features in 27 exemplary clinical, counseling, and school psychology programs. These programs share an integrated model that infuses all courses with theory and also include one or more separate courses focusing on diversity issues. This model emphasizes research training supervised by nationally recognized mentors leading toward similar theses and dissertations within a multicultural perspective. The development and supervised practice of clinical skills with diverse bilingual client populations occurs at all levels of training. Comprehensive examinations include multicultural knowledge and skills. All of these programs meet APA accreditation standards for PhD degrees in university departments. However, these exemplary programs include only one-fourth of all doctoral students in PhD programs; similar data is not available from Psy.D. programs. Moreover, since over 20% of the general population in

the United States speak a language other than English, rethinking the responsibility for language skills training in contemporary cultural competency education is now necessary.

Chapter 10 reiterates the lingering influence of an historic monocultural perspective in retarding the development of training programs that equate professional competency with multicultural competency. This rationale for professional education is now necessary to address the behavioral health and social care needs of the entire population. Cultural competency training thus includes all contemporary and emerging at-risk populations. The proposed training model essentials include early educational preparation, a program mission statement, faculty–student selection parameters, a social justice orientation, research sophistication, core competency skills and specialized training, training modalities, evaluation, and ethical issues. These essentials overlap and interpenetrate all courses, workshop, and practice throughout the entire program. For examples, in addition to methodological competencies that inform good ethnic science, trainers and programs must immerse students in a social justice rationale, provide personal growth experiences within an overarching context of safety, and continuously examine the nature and substance of ethical practices in training, research, and practice.

Integumenting these essentials in an academic program is analogous to embedding cultural competency within service delivery and services for community practice with multicultural populations. The Multicultural Assessment-Intervention Process (MAIP) model was developed for this purpose in California mental health centers. In these community settings, disposition coordination within a flexible, computerized tracking system permits an ongoing evaluation of clients, staff, training, and services in terms of outcomes. An assessment instrument, the California Brief Multicultural Competency Scale (CBMCS), provides a standard, psychometrically adequate measure of the four factors – awareness of culture, sensitivity to consumers, multicultural knowledge, and sociocultural diversities that constitute core cultural competencies within the proposed training program. The chapter concludes with a review of developing international alliances, consensual objectives, and global standards.

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