



The CAP Monitor

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Canadian Diversity and Clinical Psychology: Defining and Transcending 'Cultural Competence'

By Andrew G. Ryder, PhD and Jessica Dere, MSc, PhD student

The importance of accounting for 'culture' in the clinical encounter is widely acknowledged in clinical psychology and other mental health disciplines. The developing framework of the Mental Health Commission of Canada explicitly lists cultural issues as one of eight core concerns for the development of a comprehensive mental health policy. Unfortunately, a large gap remains between our consensus that cultural competence is important and our agreement on what cultural competence is, let alone how it should be integrated into training. Professional psychology organizations in Canada usually acknowledge the need to account for culture as part of training, accreditation, licensing, and so on, but provide little guidance on how to proceed. The aim of this paper is to consider the ways in which we can build an approach to cultural competence that: (a) is well-grounded in theory and evidence; (b) is specific to the needs of clinical psychologists; and (c) emerges from, and can be applied to, Canada's multicultural society.

Although we can certainly learn from the efforts that other countries have made to define and promote cultural competence, there are good reasons beyond pride and patriotism to make sure that our efforts here reflect the Canadian context. Multiculturalism and cultural diversity are conceived in very different ways in different countries, depending on history, demographics, and ideology (Kirmayer et al., 2007). The combination of an Aboriginal population, both British and French colonizing peoples, a century of high immigration, and resettlement of a large number of refugees, has led to a highly heterogeneous society with official policies of bilingualism and multiculturalism (Mackey, 1999). Indeed, the ethnocultural mix in Canada's cities has been characterized as 'hyperdiversity'—especially true in Toronto, but also developing in Montreal, Vancouver, Calgary, and elsewhere (Arehart-Treichel, 2004). These urban areas also differ markedly from each other, and from other parts of the country, in terms of their ethnocultural composition. We cannot simply import models of cultural competence and assume that another country's preferred ethnocultural subdivisions make sense in a given context here, let alone as part of a Canada-wide approach. Moreover, the diversity of our society is such that we might find that a group-specific approach to cultural competence is untenable.

PRACTICE PERMIT RENEWAL FOR 2010/11 FISCAL YEAR

Members should receive their application to renew their Practice Permit for the 2010/11 fiscal year in early February.

The Health Professions Act requires the College to issue practice permits for members. Without a valid practice permit, members cannot engage in the practice of the profession. To ensure your renewal application is processed in a timely and efficient manner, **please note the following:**

1. A completed Application for Renewal of Practice Permit must be received at the College office by March 31st.
2. Members will be asked to complete a criminal record declaration on the application.
3. Members must also provide evidence that they maintain professional liability insurance in an amount of at least \$1,000,000. We do not require a copy of your insurance documents; rather, members must fill out a portion of the renewal declaration regarding their insurance. Members may have adequate coverage from their employer. However, members who also engage in private practice must maintain liability insurance for work engaged in outside of the agency or institutional setting.
4. A late fee of \$100 will be assessed on all renewal applications received after March 31, 2010. The College office mails the renewal application forms no later than the first of week of February each year. The College is not responsible for ensuring delivery of renewal applications. The late fee will not be waived for reasons of slow mail delivery.
5. If you have a change of address, please make sure your updated information is received in time to be processed at the College office prior to the mail-out. Please refer to the *Psychologists Profession Regulation section 25(1)* which outlines the requirement for maintaining current contact information with the College.

NON-REGULATED RETIRED MEMBERS

In January 2006, the College introduced the non-regulated retired members register. Although retired members **do not need to renew their status** with the College yearly (as do regulated members), retired members are reminded to ensure the College has their current contact information so that they will continue to receive College publications, notices of elections, and other correspondence.

Update on the Continuing Competence Program

The Health Professions Act requirement for the College to have a mandatory Continuing Competence Program will take effect in 2011. The Continuing Competence Program to be implemented by the College is a mechanism designed for psychologists to self-assess, maintain and enhance the knowledge and skills required for competent and ethical practice.

The College is currently finalizing the draft Continuing Competence Program based upon ongoing membership feedback. All regulated members can expect to receive the revised program and an instructional DVD this Spring, 2010. **The College encourages members to watch the DVD, complete the trial Continuing Competence Program Self-Assessment Guide and Professional Development Plan and to familiarize themselves with the program requirements.**

A random call for voluntary submissions of members' professional development plans will also be made to further assist in the Continuing Competence Program development. These plans can be submitted anonymously as it is simply to assist the College in furthering the program development process.

For additional information on the Continuing Competence Program, see the CAP website at www.cap.ab.ca.

Examination Results

EXAMINATION FOR PROFESSIONAL PRACTICE OF PSYCHOLOGY (EPPP)

A total of 47 candidates wrote the EPPP examination between September 1 through December 22, 2009. Results were as follows:

Pass: 68%
Fail: 32%

ORAL EXAMINATIONS

A total of 28 candidates undertook the oral examination between October 5 and 9, 2009. Results were as follows:

Pass: 96%
Fail: 4%

Register Updates

NEW MEMBERS

Congratulations and welcome to the 23 new registered psychologists who were added to the Register between October 1, 2009 and December 31, 2009.

<i>Paige Abbott</i>	<i>Jenifer Hietala</i>
<i>Richard Amaral</i>	<i>Melanie Klemmer</i>
<i>Amanda Blakney</i>	<i>Debra Konyk</i>
<i>S. Eileen Bona</i>	<i>Janine McClelland</i>
<i>Laurie Calvert</i>	<i>Corine Mollins</i>
<i>Elvira Castaneda</i>	<i>Felicity Sara Sapp</i>
<i>Nicole Chaisson</i>	<i>Sholly Scarlett</i>
<i>Frances Chen</i>	<i>Katherine Schurer</i>
<i>Maren Conrad</i>	<i>Natashya Sherbot</i>
<i>Shanika Fridhandler</i>	<i>Janet Sommer</i>
<i>Rebecca Gokiert</i>	<i>AnneMarie Whitton</i>
<i>Patricia Hagarty</i>	

REINSTATEMENTS

Registered Psychologists

Darren George

DEATH ANNOUNCEMENT

The College has learned, with regret, of the passing of the following members:

Joanella M. Corbett
Douglas E. Anderson

The College extends condolences to their family, friends and professional colleagues.

News & Announcements

Committee News

Credentials Evaluation Sub-Committee

Wendy Hawkins was appointed as a new member and Robert Hadden was re-appointed as a member.

Hearing Tribunal/Complaint Review Committee

Irene Estay was re-appointed as a panel chair and Erik Wikman and John Roshak were re-appointed as members.

Oral Examination Committee

Erik Wikman was appointed as chair and Lee Handy was appointed as a panel chair. Dawn McBride and Sharon Habermann were appointed as new oral examiners. Ted Cadman, Gerald O. Cossitt and Marianne Miles were re-appointed as panel chairs and Debra Krueger and Ted Rafuse were re-appointed as oral examiners.

Practice Advisory Committee

Jana Davies was re-appointed as a member.

Registration Advisory Committee

Patricia Schuster was appointed as a new member and Derek Truscott and Walter Goos were re-appointed as members.

Registration Approvals Sub-Committee

Stan Mlynczak was appointed as a new member.

Many Thanks!

We appreciate each and every one
of our volunteers. The work of the
College could not thrive without
their continued support and
contributions.

COLLEGE STAFF UPDATE

The College office is pleased to welcome a new staff member, Dr. Joanna Dabrowski, who has been hired to fill the vacant Deputy Registrar and Director, Professional Guidance position effective April 1, 2010. Joanna has an extensive background in forensic psychology and has served in the past on College committees, as well as a PAA Practice Advisor. She will be applying her experience and expertise to assist the College in implementing its Strategic Plan, and continued development and implementation of the mandatory Continuing Competence Program. Joanna will be working closely with the advisory committees of the College as well as undertaking the oversight of the College's publication, *The CAP Monitor*.

Dr. Richard Spelliscy has moved to his new position as Complaints Director in January.

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The Canadian reality is one impetus to finding ways to think about cultural competence beyond skills training for work with defined groups. Another reason is that this view has been rejected, conceptually and empirically, by researchers who take culture and cultural variation as central concerns. Our perspective draws in particular on anthropology and cultural psychology as sources of theory and basic research, along with the interdisciplinary research and clinical endeavour most often known as cultural psychiatry. Although these disciplines have generated numerous definitions of 'culture,' Jenkins and Karno (1992) provide a relatively simple one, albeit one with complex implications; culture is, "a generalized, coherent context of shared symbols and meanings that individuals dynamically create and recreate for themselves in the process of social interaction" (p. 10). Our reflection on cultural competence in Canada will begin with a brief summary of the perspectives offered by anthropology, cultural psychology, and cultural psychiatry, before turning to some concrete suggestions about how cultural competence training could be integrated in a more sustained way into our graduate training and internship programs.

CULTURE: THREE APPROACHES

Cultural Anthropology: A Nuanced View of Culture

Before we consider the meaning of cultural competence in more detail, we need to take a step back to consider the meaning of 'culture.' The goal here is not to arrive at a single consensual definition of culture—a difficult, if not impossible, task—but rather to reflect upon various ways in which culture can be understood. Medical anthropologists rightly argue that typical notions of culture found in health care settings are overly simplistic, often little more than a shorthand for other demographic variables—for example, racial category, ethnic background, country of origin, or first language (Kleinman & Benson, 2006). This approach to culture is not only limited, but also potentially hazardous, by making it easy to proceed with broad generalizations and cultural stereotypes. A more nuanced view of culture, and of what culture can represent for different people from different groups, is key to our view of cultural competence.

To this end, much that can be learned from cultural anthropologists for whom culture is the main object of concern and subject of debate. Recent decades have seen profound shifts in the ways that culture is understood in anthropology—shifts that offer a challenge to those of us in other disciplines who attempt to take culture seriously. There has been a fundamental move away from traditional depictions of separate and distinct cultures as 'bounded units' (Mathews, 2000) accompanied by an increasing emphasis on culture as complex, dynamic, fluid, and contested. We cannot identify an individual client with a group, learn about the beliefs, values, practices, and so on, of that group, and then assume that they apply in textbook form—or at all—to the individual client. Additionally, there has been a growing emphasis on the vast array of cross-national ties and inter-cultural influences that are present in our increasingly globalized world, which have profound impacts on group and individual identities. Indeed, cultural anthropology has increasingly focused on the hybridization of culture and cultural identities, whereby transnational flows of people and information interact to form new cultural realities (Kirmayer, 2006).

Cultural anthropology also highlights the importance of both the local and global contexts in which cultural values, beliefs, and practices are situated. These features are seen as distributed among a population, rather than being contained within each member of a group. For example, in many groups, theological doctrine will be understood most thoroughly by trained religious functionaries, rather than by all group members equally. In order to capture this intra-group variation, anthropological methods tend to be small-scale, in-depth, and qualitative, emphasizing how group members engage with cultural knowledge, norms, and practices. Inevitably, individual people vary in the extent to which they endorse, engage with, and follow the cultural practices of a particular group; they also vary in the extent to which a given cultural membership is an important part of their identity. Furthermore, culture is seen to both include and interact with such

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variables as age, gender, socioeconomic status, social roles, professional identities, and so on. By highlighting all of these myriad facets of culture, anthropologists have established that within-culture variability exists and that accounting for it is vital to an understanding of both cultural context and the individual people who comprise it. We believe that greater recognition of this variability is an important part of any approach to cultural competence that seeks to go beyond group-specific guidelines.

Anthropologists also remind us that a broad view of culture goes beyond ethnocultural groups to encompass a range of subgroups, importantly including our professional identities. In other words, theory and practice in clinical psychology are also socioculturally shaped. Medical anthropologists, in particular, have demonstrated how aspects of clinical encounters that are frequently regarded as somehow 'acultural'—such as assessment and diagnosis—are, in fact, deeply rooted in particular contexts. Current clinical psychological frameworks and therapeutic approaches are the product of a specific constellation of historical, sociopolitical, and cultural influences. That there can be widely divergent disciplinary subcultures, even in a shared domain such as mental health, will not be lost on anyone who has worked on an interdisciplinary team. These observations highlight that culture is not only located in our clients; we enter clinical settings with a specific set of shared meanings that come from clinical psychology, in addition to our ethnocultural backgrounds.

Cultural Psychology: The Cultural Shaping of Psychological Processes

Although important to any consideration of culture, anthropological arguments can seem somewhat abstract to clinical psychologists who are usually trained in a very different research tradition. The rapidly growing sub-discipline of cultural psychology is more familiar territory at first impression; cultural psychologists tend to use familiar quantitative methods and do so to ask recognizably psychological questions. In many ways, however, the perspective of cultural psychology may be just as radical in its claims about the interrelation of culture and self, and perhaps more so in the ways in which many of the field's findings cast doubt on long-held assumptions in mainstream psychology.

Indeed, the core theoretical assumption of cultural psychology is pithily summarized in the claim that culture and self 'make each other up' (Shweder, 1990). The self cannot be understood without accounting for how deeply it is shaped by culture; a cultural group cannot be understood without accounting for the selves that constitute it. In this view, cultural group cannot simply be an independent variable, but must be thoroughly explored as a central domain of psychological inquiry. The intimate connection between culture and the self is exemplified in the distinction between independent and interdependent self-concepts (Markus & Kitayama, 1991). A rich body of work based on these contrasting views of self has demonstrated that people who have been raised in different cultural contexts vary considerably in the extent to which they incorporate aspects of close others into their self-concept, a variation which, in turn, has consequences for a wide range of psychological variables. The chance to stand out motivates the independent self; the chance to fit in motivates the interdependent self. Psychological health in adults is characterized by self-sufficiency and independence from parents when the cultural context encourages the independent self. A client with a well-developed interdependent self may come across as less healthy in such a context, perhaps labelled as 'enmeshed' in their families.

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Cultural psychologists have gone beyond independence and interdependence to investigate a wide range of psychological processes. To choose some clinically relevant examples, recent studies have shown significant cultural variations in emotional expression (e.g., Tsai, Levenson, & McCoy, 2006), emotion socialization (e.g., Wang, 2001), motivations for self-consistency and self-esteem (e.g., Suh, 2002), the types of emotions associated with well-being (e.g., Kitayama, Markus, & Kurokawa, 2000), and the extent to which personality traits are internally consistent and stable (e.g., Heine & Buchtel, 2009). Intriguingly, variation has also been demonstrated in processes previously thought to be too 'basic' or 'low level' to be influenced by culture. For example, Masuda and colleagues (2008) demonstrated that in judging the emotional expression of a central character in a cartoon image, Japanese students, as compared to Euro-American students, placed greater importance on the emotional expressions of surrounding characters. Rather than being limited to self-report, these results were confirmed using eye-tracking methods, which showed corresponding patterns of visual attention to the presented scene. As another example, there is emerging evidence that cultural variation in certain cognitive tasks is accompanied by different patterns of brain activation using fMRI (Hedden et al., 2008).

The findings listed above help highlight the extent to which traditional assumptions regarding the universality of various psychological processes needs to be questioned in light of cross-cultural findings, and in light of the expansion of the psychological research base outside of North America. For example, the critical importance of maintaining a high level of self-esteem has long been assumed to be a basic human motivation. However, recent cultural psychological work strongly argues that the continual pursuit of high self-esteem is grounded in individualistic values and the independent self-concept, and is not a universal concern (Heine, 2007). In addition to highlighting the importance of cross-cultural research for the general field of psychology, these findings also demonstrate the extent to which culture plays a role in shaping human experience. If culture has an effect on such 'basic' processes as emotion, cognition, and motivation, it demands more than passing attention in the clinic.

Cultural Psychiatry: Culture in the Clinic

Anthropology and cultural psychology have much to offer the clinical psychologist grappling with cultural competence, but neither field has had to engage directly with the practical challenges of assessment and treatment. For an example of such an approach we must turn to cultural psychiatry, the product of a longstanding relationship between psychiatry and anthropology at certain institutions. Cultural psychiatry represents the best attempt so far to unite clinical and cultural domains and, for our purposes, has the added advantage of a strong Canadian presence. Recent work by cultural psychiatrists has included a detailed analysis of the ways in which the fundamental principles of dominant psychotherapeutic models closely parallel key features of the 'Western' self; for example, emphases on personal autonomy, individual expression, and the pursuit of happiness, along with a relative lack of attention to context (Kirmayer, 2007). Cultural psychiatrists argue that by recognizing the ties between conceptions of self and therapeutic models, clinicians can better consider whether or not traditional therapeutic approaches are well suited to a given client. Such findings can have a direct impact on cultural competence in practice.

At its best, cultural psychiatry has been a fruitful interdisciplinary endeavour, encouraging researchers and clinicians from a wide variety of disciplinary backgrounds to work together, mirroring multiculturalism in its

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academic diversity (Kirmayer et al., 2007). Unfortunately, clinical psychology has not been well represented in this discussion, despite being the other major field with a sustained interest in training clinicians who are also researchers, and vice versa. The result is that when cultural psychiatry forwards practical suggestions for cultural competence training, there is an understandable focus on the needs of medical students and residents working in hospital settings. Rather than mimicking the exact approach of cultural psychiatry, we can learn from the ways in which they have succeeded in developing their field.

Toward a Cultural-Clinical Psychology

The three disciplinary perspectives described above can contribute to a richer notion of cultural competence for the Canadian situation. Anthropology serves as a reminder of the complexity inherent in the very idea of 'culture.' Clinical psychologists have long had an uneasy relationship with the categorical model of mental disorder found in the third and fourth editions of DSM. If we are rightly skeptical about whether 'Major Depressive Disorder' describes a discrete and natural kind, we should be downright suspicious of any attempt to reduce cultural complexity to broad national labels, such as 'Chinese' or—worse—'Asian.' In contrast, cultural psychologists make frequent use of these labels, but ideally do so provisionally for the sake of convenience. Rather than assuming that membership in a Japanese group automatically means adherence to collectivistic values, one might focus on such a group nonetheless to study contexts where these values are more common. Clinicians, similarly, should not assume that a cultural label answers questions that they may have about a particular client, but can use such labels tentatively and pragmatically to generate potentially relevant questions.

Cultural psychiatry, finally, offers an example of a similar path being taken for somewhat different ends. Clinical psychologists interested in cultural issues would do well to promote and maintain an open dialogue with this interdisciplinary and clinically relevant field, while continuing to attend to the particular needs of our discipline. One lesson we might draw from cultural psychiatry is that there are advantages in developing a subgroup of researchers and clinicians who really specialize in this area. These cultural-clinical psychologists would be scientist-practitioners and clinician-scholars with dual training and experience in cultural and clinical psychology, who conduct a major portion of their research and/or clinical work in the area of culture and mental health. Cultural-clinical psychologists can then take the lead in developing approaches to cultural competence that can: (a) improve the quality of teaching in this area; (b) generate training opportunities and materials; and (c) inform guidelines for accreditation and licensing.

Competence: Achieving It, Getting Past It

There are ample opportunities for clinical psychologists grounded in cultural work—cultural clinical psychologists—to contribute to the discussion on cultural competence. Calls for greater inclusion of cultural issues into graduate training, supervision, internship, and licensing are increasingly being made by national and provincial psychology organizations, but are generally unaccompanied by concrete suggestions. This in itself might be a good thing, as we do not yet know enough to make specific proposals; but a conversation about our options should be underway. The danger is that we create expectations for cultural competence training in a vacuum, and then models developed elsewhere rush in to fill that vacuum.

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Defining Cultural Competence

The term 'cultural competence' itself should perhaps be used with caution, as it too is a product of its own background. In trying to develop a Canadian clinical-cultural psychology, we benefit from the work that has been done by American psychologists and others who have dealt with broadly similar problems. At the same time, we need to be aware that the American approach to cultural competence is derived from the American experience of cultural diversity in some very specific ways. Most prominently, cultural diversity in the United States is frequently characterized by the division of society into large ethnoracial blocs—European American, African American, Latino, Asian American, and Native American. To the extent that culture is confounded with these blocs, competence becomes the acquisition of bloc-specific knowledge and clinical skills. Competence with Latinos, for example, becomes equivalent to competence in forensic assessment or program evaluation, a checklist of specific 'competencies.'

In addition to the incredible heterogeneity contained within each category, there is an implicit hierarchy of membership within each category. 'African American' is a better fit to Black Americans with long family histories in the U.S., and not such a good fit to a recent immigrant from Ghana; 'Asian American' covers origins throughout the vast Asian continent, but is often used to mean East or Southeast Asian (e.g., Chinese, Japanese, Vietnamese); 'Latino' describes Spanish-speaking Puerto Ricans better than Portuguese-speaking Brazilians, let alone Dutch-speaking Surinamese. If cultural competence is group-specific knowledge and skill, we either have to gloss over this diversity or expand the number of groups to be considered. The first approach represents a gross oversimplification; the second risks making cultural competence all but impossible. The clinician who searches conscientiously for the manualized skill set appropriate to every specific ethnocultural group they encounter will soon give up on cultural competence altogether.

The specific history of ethnocultural groups in Canada, along with the hyperdiversity apparent in large Canadian cities (which we suspect is also true of many large American cities), argue equally against importing an ethnoracial bloc classification or attempting to develop a made-in-Canada equivalent. We need to move away from a conception of cultural competence in which (a) clients 'come from' a specific and easily identifiable cultural group, which (b) leads the client to display certain fixed characteristics which, in turn, (c) lend themselves to specific clinical interventions. There is a danger that cultural competence could come to be seen as either banal or impossible, as requiring nothing more than 'acknowledgement of the client's background' or as requiring dissertation-level inquiry into the cultural anthropology of every group represented in a given clinical setting.

Given the immense challenges of really getting to know another cultural worldview, ethnic matching is often proposed as the best way of ensuring group-specific cultural competence. In our view, this approach has its place as a potential solution to specific local problems but is a dead end as a general solution. First, the effect would be to ghettoize minority clinicians as specialists in the problems of their 'own' groups, leaving Euro-Canadian clinicians as well-rounded generalists who can focus on the 'real' problems. Second, the requisite number of minority clinicians would not necessarily be available, especially outside of the largest cities. Third, clients from demographically small ethnocultural groups could find it very difficult to locate clinicians who feel competent to work with them. Finally, it is not necessarily the case that clients always want to work with people who come from a similar background; indeed, under some circumstances, a match may be seen as

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a disadvantage. For example, a given client may be particularly concerned about stigma or about being judged if the clinician comes from, or even seems to come from, the same ethnocultural community.

Teaching Cultural Competence

Training in graduate school and internship settings will be central to defining and disseminating a Canadian approach to cultural competence for clinical psychologists. We have argued that such competence cannot be group-specific, but rather should involve knowledge about and comfort with the implications of cultural difference. Below, we briefly outline four ways in which this approach could be incorporated into training.

Coursework. Students in clinical psychology arguably have more than enough courses as it is, and there has been a tendency to introduce every new training idea by insisting on a new course. There are ways of ensuring that these topics are in the curriculum without increasing the overall burden, however. One option would be to make sure that all the courses include culture-relevant content. The challenge here would be to ensure that culture-related seminars fit together coherently and build on previous knowledge, not easy with a number of instructors and a lack of training materials. Faculty members with a background in culture and mental health could serve as consultants on these topics across the various courses in the curriculum. A second option would be to design a specific course on the topic and offer it either as an elective or as a way of filling a program requirement (e.g., as a course on the social bases of behaviour). Such a course would allow more time to be spent on the concepts and research from cultural psychology and related disciplines before applying them to mental health issues. There would also be more opportunity to tackle related issues that are often neglected, for example, family systems, religion, values, gender roles, social class, racism, and discrimination.

Supervision. Ideally, clinical supervision would consider the cultural aspects of all cases, rather than identifying particular ethnocultural minority patients as 'multicultural cases.' A tenth generation Euro-Canadian client also lives within a cultural context, and that context may well be very different from that of the student therapist. Culturally competent supervision can range from reminders about issues to keep in mind (e.g., extended family, religious faith) to assistance during times when these issues pose challenges to the student (e.g., antipathy toward patriarchal family structures or traditional religious belief). Supervised experience working with translators, culture-brokers, and/or family members is very helpful, as is exposure to a range of populations including immigrants, refugees, or first nations community members. Indeed, we would argue that keeping track of these kinds of categories is more important than tracking exposure to specific ethnocultural groups. At the same time, sustained experience with a number of different clients from the same ethnocultural background can be invaluable; here, the specific group is less important than the experience of encountering the range of individual differences that can be contained within a specific label.

Local knowledge. Doctoral and internship training should include learning about the local context of the university or training site, an approach which owes more to anthropology than to common practice in clinical psychology. Topics could include the demographics of majority and minority ethnocultural groups,

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neighbourhood compositions, local issues, migration and minority histories, community relations with larger power structures (e.g., health care system, legal system), and so on. Students could also be made aware of mental health and community resources, and issues of access to these resources. To the extent that students can be directly engaged in the process of acquiring and improving their local knowledge, they will become more aware of what is involved in learning about a new context. The end result would be that the knowledge might be local, but awareness of its importance and the ability to learn it anew would be highly transferable.

Clinical openness. We suspect that the traits that help to make a good clinician will also help to make a culturally competent clinician and, moreover, that multicultural clinical encounters cast these traits in bold relief. Empathic curiosity about the varieties of human experience—normal, abnormal; familiar, unfamiliar—is crucial, as is tolerance for the uncertainty and discomfort inevitably to be faced along the way. Willingness to encounter the other, when fully engaged, brings with it a decentering of the self and its assumptions. In seeming contradiction to what we have said before, students should indeed become specialists in a particular ethnocultural group—their own culture, as a culture. The goal here is perhaps not so well described by 'cultural competence', but rather as cultural humility combined with the pragmatic confidence required to work effectively. Here, the best contribution to training we can make is the development of a milieu where such an approach is the norm with all of our clients.

Conclusions

Theory and research from anthropology, cultural psychology, and cultural psychiatry underscore the central importance of culture to understanding people and hence to clinical work. We believe that integrating complex views of culture into clinical work is difficult enough to benefit from collaboration among clinical psychologists for whom culture is a central concern, perhaps leading to a sub-discipline of cultural-clinical psychology. We equally believe that this integration is crucial enough to warrant broad engagement by clinical psychologists in this ongoing discussion, leading to concrete implications for teaching and practice. The complex notions of culture we have advocated here may at first seem more difficult than an approach that keys specific skills to broad ethnocultural groups, but we would argue that this complexity is necessary for—and well suited to—Canadian society. Given that quite a few other countries are dealing increasingly with high levels of diversity, a Canadian approach to cultural competence has the potential for a wider influence.

We agree that cultural competence can be taught up to a point: skills can be learned, training requirements can be set. At the same time, cultural competence should equally be seen as a general orientation combined with a set of aspirations. Rather than just being a specialist niche, we believe that training and experience in working with cultural difference can help one to become a better clinician with all clients—not least, because all clients have a culture. At the same time, we suspect that the reverse is not the case. Because cultural differences are pervasive enough to shape the assumptions of clinical psychology and the practice of therapy, one should not assume that good general clinical skills will automatically translate into cultural competence. Ultimately, we hope that this distinction, between general and cultural competence, will grow increasingly artificial as cultural issues continue to move from the periphery to the centre of concern for clinical psychologists.

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About the Authors

Andrew Ryder is Assistant Professor in the Department of Psychology at Concordia University, where he directs the Culture, Health, and Personality Lab (www.chp.concordia.ca). His research interests revolve around the ways in which cultural psychology and clinical psychology perspectives can be combined to better understand cultural variation in psychopathology, and the consequences of this variation for assessment and psychotherapy. He is currently conducting CIHR-funded research into the relative contributions of illness beliefs, cognitive styles, personality, and stigma in the presentation of depressive symptoms among Han Chinese, Koreans, and Euro-Canadians. Other work includes research on mental health implications of acculturation and multicultural identity, cultural variation in social anxiety, and the interrelation of depression, personality, and personality disorders.

Jessica Dere is currently a doctoral candidate in the Clinical Psychology program at Concordia University, working under the supervision of Dr. Ryder in the Culture, Health, and Personality lab. Her research interests lie at the intersection of clinical and cultural psychology, and she is focusing her doctoral research on the ways in which illness beliefs and cognitive styles lead to cultural variation in depressive symptom presentation among Han Chinese and Euro-Canadians. She is supported by a doctoral fellowship from the Fonds de la recherche en santé du Québec (FRSQ).

Information on the Agreement on Internal Trade

On July 18, 1994, First Ministers signed the Agreement on Internal Trade (AIT) which came into effect on July 1, 1995. The AIT aims to reduce barriers to the movement of persons, goods, services and investments within Canada.

The ninth protocol to Chapter 7, Labour Mobility, was ratified by all provinces and territories on August 9, 2009 and came into effect immediately. Amendments described in the revised Labour Mobility chapter will provide barrier-free mobility across Canada and license-to-license registration for psychologists that are registered in other Canadian jurisdictions. Any additional requirements that are imposed by any jurisdiction would have to be linked to demonstrated differences in occupational standards or scopes of practice (see Agreement on Internal Trade, Chapter 7, Labour Mobility).

The College is now ready for full implementation of the Agreement and the Government of Alberta has advised the College that we are in compliance with the AIT. For information on the AIT implementation in other jurisdictions, contact the regulatory body directly.

CHANGING YOUR ADDRESS?

Please notify the College promptly, in writing, of any changes to your postal address, phone and fax numbers, or email address. A Change of Address Form is available on the College website.

Please note that information about your business address, phone and fax number, and email address is available to the public. If you are providing a residential address to the College, clearly indicate this on the Change of Address Form so that this information will be kept confidential.

If you have an email address, you are encouraged to provide it to the College to facilitate more efficient communication.

Resources

CAP PUBLICATIONS

The following CAP publications are available on a cost-recovery basis from the College office as well as on our website:

1. CAP professional guidelines for psychologists (copies available individually or as a package), including:
 - Addressing Recovered Memories
 - Advertising and Other Public Communication
 - Child Custody Assessment
 - Control and Use of Tests by Psychologists
 - Dual Roles: Guidelines for Conducting Assessments and Providing Therapy with the Same Client
 - Informed Consent: Ethical Guidelines, Principles and Standards
 - Limits to Confidentiality and Consent for Services: Special Issues in Working with Minors and Dependent Adults
 - Non-Discriminatory Practice
 - Psychological Evaluations for Child Protection Decisions
 - Release of Confidential Information: Special Issues in Client and Third Party Requests
 - Service Fees for the Provision of Copies of Client Files
 - Supervisors and Registered Provisional Psychologists
 - The Use of Aversive Techniques in Behaviour Management
2. “Status of Regulatory Documents in the Regulation of the Psychology Profession in Alberta”
3. “Receiving Services from a Registered Psychologist ...” (brochure)

ONLINE RESOURCES

The College’s website at www.cap.ab.ca serves two purposes: communication with the public and communication with CAP members. The website is updated regularly and is a good source of information.

OTHER USEFUL WEBSITES FOR CAP MEMBERS

- Health Professions Act—www.gov.ab.ca/qp
- Psychologists’ Association of Alberta—www.psychologistsassociation.ab.ca
- Canadian Psychological Association—www.cpa.ca
- Association of State and Provincial Psychology Boards—www.asppb.org



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