Training of Health Professionals

1. Introduction

The major challenge faced nowadays by the healthcare system in pluralistic states characterized by an important immigration history, is that the multicultural composition of the population asks for a health system that takes into account differences in needs, beliefs and practices concerning health and healthcare delivery. This systems is to pursue a dynamic and holistic approach of health encompassing the physical, mental and social well being (e.g. quality of life, social and economic security, good education, healthcare system accessibility, mobilisation of potentials), and is committed to the development of framework conditions for equal opportunities and integration (equal participation of migrants in social, political, economical life, mutual respect for differences).
In order to respond to a society and clientele whose nature and needs have changed as a result of migration, the strategy's main objective is the reorientation of the healthcare system towards the needs of a pluralistic and heterogeneous society.

1.1. Understanding the reaction of the healthcare system to pluralistic socities

This thematic area is expected to highlight research issues that should better illustrate the ways in which the healthcare system react to the pluralistic composition of the given countries. Several research issues are linked to this thematic area, in particular doctor-patient relationship; interactions and communication between care providers (medical and non-medical professionals) and patients; patients' and care providers' decision-making and factors affecting th decision-making process; psychosocial issues and emerging interdisciplinary paradigm. At this level, literature review show that it is essential to better acknowledge how ethnicity and social factors (e.g. gender, legal status, social class) influence patients' interactions with the range of healthcare professionals (medical and non-medical profession) with whom they come into contact. A large amount of research, especially in US (cf. Murray-Garcia, 2002; Smedley et al., 2003), has been focused on the impact of ethnic concordance/discordance between physicians and minority patients on communication, decision-making and mutual perception, and the impact of these variables on health outcomes and satisfaction (Cooper-Patrick et al., 1999; Saha et al., 2000; Cooper and Roter, 2003). As in Switzerland ethnic providers remain a small fraction of the overall healthcare force, ethnic concordance/discordance research may not appear a priority. However, these studies highlight the importance of better documenting social and ethnic factors that affect communication, mutual perception as well as decision-making and service delivery.
Further studies should focus on decision-making by patients and care providers, on the assessment of care management at different points along the continuum of care, and on the impact of patient provider interactions on diagnosis and treatments (Smedley et al. 2003). For instance, additional research is needed on provider decision-making heuristics employed in diagnostic evaluation (Wennberg, 1999), and how patients ethnicity and other social factors such as gender, social class, legal status may influence these decisions. Experimental research has been conducted to assess the extent to which physicians' treatment recommendations differ by patient ethnicity and gender (Schulmann et al., 1999).This research should be expanded to explore how social cognitive processes (e.g. bias, stereotypes, cf. Dovidio, 1999; Mackie, Devos and Smith, 2000; Operario and Fiske, 2001) may affect patients' and providers' conscious and unconscious perceptions of each other and influence the structure, processes, and outcomes of care (van Ryn and Burke, 2000; Balsa and McGuire, 2001). The attention should also be focused on the impact of

ethnicity and social factors on the quality of patients and providers relationship, communication, and interaction (Krupat et al. 1999; Cooper-Patrick et al., 2000; Cooper and Roter, 2003), for instance in terms of symmetrical or asymmetrical relationship, empathy, mutual comprehension, treatments observance, symptoms expression, mutual trust (cf. the reference to patient-centeredness in medical communication research, Mead and Bower, 2000; Sullivan, 2003). To this respect, a better definition of communication and interaction qualitys criterions is needed -matching both providers and patients perceptions and needs- also in order to identify to which extent particular characteristics of the interaction/communication process affect diagnosis, treatments and health outcomes. In addition, further research should better determine whether structural, institutional and organisational factors of healthcare settings affect the content of care and quality of communication for migrant patients (Weiss, 2003).

As Smedley and collegues (2003) have pointed out, it is worth noting that within the vast majority of research that documents ethnic disparities in care, decision-making and communication processes have been focused on the role of the physician. This fail to consider that much of healthcare is provided by nonphysician professionals (e.g. nurses, occupational and rehabilitation therapists, psychologists, social workers). The roles of other hospital and clinical staff (receptionists, community interpreters, intercultural mediators) are also central in contributing to the climate in which care is delivered. These professionals play a significant role in conveying messages of respect and dignity and in influencing how patients feel about the healthcare setting (Habermann, 2000; Kingsley, 2001). Research is needed to assess how these individuals perceive, interact and communicate with migrants, and how patients respond to them.

Further research should also assess how educational programs can improve staffs (physicians and non-physicians) attitudes, behaviours, and communication with migrants (e.g. transcultural communication, Luckman and Tindell Nobles, 1999; transcultural education, cf. Donini-Lenhoff and Hendrick, 2000; Nunez, 2000). The development of questionnaires or other forms of self-assessment to measure care providers attitudes and stereotypes is also recommended (Paniagua et al., 2000). Research is critically needed in order to study interactions, forms of communication and problems of contact between migrants and the range of healthcare professionals (Smedley et al., 2003). To this respect, it is also essential to better clarify legal, structural and financial possibilities of the healthcare system for the improvement of the communicationprocess with migrants (Weiss, 2003). Further, strategies to increase migrants patients ability to participate in treatment decisions and empower them as selfadvocates within the healthcare system should be studied (Roter and al, 1998). It is important that such research are conducted in active collaboration with ethnic communities and representative associations, in order to match cultural knowledge and traditions that may serve as source of strength in the effort to empower migrant patients.

Another major challenge for the healthcare system is how to deal with mental suffering and psychosocial problems of migrants. First of all, lack of data concerning psychosocial health problems of migrants is observed (Chimienti and Cattacin, 2001). In fact, hospital discharge records and physicians reports do not generally yield data concerning migrants specificities. The absence of these data does not permit to have a clear view of the most frequent psychosocial problems of migrant patients. Therefore, research is needed in order to set up statistical data concerning the most common psychosocial health problems of migrants that takes into account a pertinent range of variables differentiating these groups of patients (cf. Bischoff and Wanner, 2003). Representative surveys concerning the psychosocial health of different groups of migrants are also required. A lack of psychosocial and medical case-control studies on specific risks linked to migration for different groups of migrants is also noticed in the literature (Weiss, 2003). In addition, research that aims the verification of the impact on mental and psychosocial health of a series of variables linked to migration (e.g. language proficiency, legal status, integration, motivation of migration, expectancies and attitudes relatives to the host country, social policies) is required (Zenker, 2000).

Research is critically needed also for culturally sensitive diagnosis and treatments of psychosocial sufferings, and for the comprehension of theirs causal factors (etiology). Concerning diagnosis, a further development of innovative multidisciplinary lines of research is demanded in order to assess early diagnostic of psychosocial morbidities related to migration (Riecken, 2001). As for psychosocial treatment and assistance, it is important to better analyse the possibilities and difficulties of care giving to migrants in the realm of medical and hospital practices (Weiss, 2003).

Innovative and multidisciplinary models of psychosocial treatment and assistance should be further developed (Eberding and Schlippe, 2001; Faltermeier, 2001), matching migrants cultural needs and practices as well as their health perceptions (development of a culturally sensitive therapeutic concept). Concerning research aiming to study the etiology of psychosocial problems of migrants, it is necessary to take into account a large variety of variables linked to migration (e.g. language proficiency, legal status, origin, integration, motivation of migration, expectancies and attitudes relatives to the host country, social policies), and to differentiate migrants in distinct relevant demographic categories (e.g. origin, age, gender, social class). In addition, more attention is to be devoted in the future to the development of holistic approaches of diagnosis, etiology and treatment of psychosocial problems of migrants (Watters, 2001).
An holistic approach suggests that rather than impose a dualism which seeks to define if the client has a physiological or a psychological problem, it may be more appropriate for clinicians to ask patients for their own view regarding the etiology of their conditions, and choice of treatment.
Emerging interdisciplinary perspectives (e.g. medical anthropology, cultural epidemiology, -integrating anthropology and epidemiology, cf. Weiss, 2001; transcultural psychiatry, a psychological approach of migration -situated at the frontier of psychology, intercultural psychology and health), taking into account the multicultural population composition, should be further developed. Analysis of their potential for interdisciplinary research and intervention in the domain of healthcare and health prevention (or promotion) is recommended, at both conceptual and methodological level (Weiss, 2003).Finally, meanings of healthcare systems and practices changes for professionals (e.g. the necessity of collaboration and coordination between medical and social sciences -derived from migration and the multicultural composition of modern societies) should be carefully studied in order to assess and manage potential professional identity crisis or conflicts (Rossi, 2002).

2.2. Understanding barriers and disparities in healthcare

Migrants have generally reduced access to healthcare in receiving societies for a number of political, administrative and cultural reasons that are not necessarily present for the native population, which vary in different societies and for different minority group. Language, different concepts of health and disease, or the presence of racism and xenophobia are examples of such selective barriers. Barriers to healthcare and under-utilisation of services by migrants is often observed by the literature, both in US and Europe. The limited availability of interpreter or cultural mediation services in most host countries is believed to pose considerable linguistic and cultural barriers to appropriate medical services, particularly for the most disadvantaged segments of migrant groups (e.g. newcomers, women, elderly). Existing evidence reports that economic and administrative barriers to healthcare prevail in those countries that do not readily grant citizenship, and thus full social and political rights, to settled immigrants (Bollini, 1993). In addition, xenophobia and discrimination within the health services is often reported in the literature (Schulman, 1999; Smedley et al., 2003), both in employment of personnel from ethnic groups and in the delivery of services. Prejudice often assumes that the alien culture is inferior and somehow pathogenic, and patients behaviour inappropriate (van Ryk and Burke, 2000). The presence of discrimination (and perceived discrimination) creates additional barriers in the utilisation of healthcare services. The level of entitlements for migrants in receiving societies (which is believed to vary according to their legal status in the host society, to social and political rights, and according to the degree of institutional and social discrimination

against people of different ethnic backgrounds), is believed to affect both health outcome and access to healthcare (Bollini, 1997). Indeed, more data are needed to document the relationship between level of entitlements of migrants in the host country and access to healthcare, as well as health outcomes, in order to promote effective countermeasures.

The prevailing attitudes and politics toward immigration in receiving countries influence not only migrants' social status and entitlements in the society but also the response of the healthcare system to their specific needs. As Bollini and Siem (1995) have pointed out, two broad categories of reactions are observed in host countries: a "passive" attitude, in which migrants are expected to make use of the existing health system with no major modification (also if actions are taken for cultural differences and linguistic barriers), and an "active attitude, in which the special health needs of migrant communities are acknowledged and actions are taken by the health authorities to ensure that linguistic and cultural barriers are minimized. Research evidence (Bollini, 1993) suggests that an "active" attitude, in other words the adoption of specific health policies (and the creation of specific services) for migrants, could remove many economic, administrative and linguistic barriers to access to health care. This pluralistic (or multicultural) approach7 has been accompanied in some receiving countries (e.g. Australia, Canada) by the development and improvement of services for migrants, and increased recognition of the need for services to cater for the cultural diversity of the population.

Nevertheless, an overemphasis on culture at the expense of other social determinants of health and access to the health system such as socio-economic status, gender or the broad social policy context (Watters, 2001) is criticized in the literature (Ahmad, 1996; Eastmond, 1998; Dozon and Fassin, 2001). Focus on the idiosyncrasies of different cultures in a stereotypical way is believed to lead to situations where culture is seen as the cause of health disparities, which in turns results in a tendency to blame the victims. In addition, it is argued that variation within the cultures may be greater than variation between cultures. This literature should not be interpreted as minimising the importance of culture. Rather, it suggests that effective services will depend on taking into account the actual rather then perceived sources of diversity within and between communities. Specific health services should be developed on an analysis of community needs, rather then on the assumption of primary differences between populations on the basis of culture. Research aiming the recognition and assessment of a diversity of needs within and between communities is expected to lead to a more evidence-based approach to specific services design, matching communities' needs, health perceptions, and current pattern of utilisation (Kelaher and Manderson, 2000). As Watters (2001) has suggested, the establishment of focus group may be a useful mean of prioritising proposals for the setting up of specific services relating to communities' health and social needs, countering the prevalence of stereotypical ways and assumptions regarding needs of particular migrant groups or communities.

The role of language as an important barrier to healthcare has been largely documented in the international international (Morales et al., 1999; Pitkin and Baker, 2000; Bowen, 2001; Robinson and Gilmartin, 2002; Murray-Garcia, 2002). However, less research attention has been devoted to assessing intervention efforts then to understand the extent of barriers to healthcare. More research efforts should be focused on intervention strategies such as transcultural education and communication training for healthcare providers (Purnell and Paulanka, 1998; Canales, 2000; Robins, White et al., 2001; Smedley et al. 2003), community interpreting and intercultural mediation
(Jacobs, Landeral et al. 2001; Nierkens, Krumeich et al., 2002; Singy, Weber and Guex, 2003). As Bischoff (2001) has pointed out, research is expected to assess not only the effectiveness of these interventions in reducing gaps in appropriate care delivery and healthcare access (as well as health outcomes), but also their cost-effectiveness and the extent to which these interventions result in organizational and institution-level changes to improve care for migrant patients.

Qualitative research is also needed with input from medical anthropology and social sciences. In the area of communication, an adequate quantitative/qualitative mix is essential in obtaining reliable data. Moreover, patients' psychosocial aspects influencing understanding and communication should be more closely analysed, since they shape as well the translation of meaning. Research is needed also to better clarify the

concept of transcultural competence (Domenig, 2001; Donini-Lehnoff and Hedrick, 2000; Nunez; 2000; Carrillo et al., 2000) and its related elements, and to determine the content and forms of transcultural education for the entire range of health professionals (medical and social care providers, nurses, therapists, interpreters, cultural mediators, and so on). Comparative studies on different existing models of transcultural or cultural competence (see also the concept of cultural humility which is intended to replace cultural competence in incorporating a lifelong commitment to self-evaluation, self-critique and non-paternalistic interaction instead of a finite body of knowledge, cf. Trevalon and Murray-Garcia, 1998) should also be conducted, in order to assess their impact on health outcome and access to health care (and on patients and care providers satisfaction).

The impact of economic and legal barriers to healthcare access (e.g. immigration law restrictions, legal status, insurance system) should also be further documented (Weiss, 2003). Moreover, it seems necessary to better understand the extent to which perceived discrimination and hostility experienced by migrants (both in society and in the healthcare system) has an influence on healthcare utilisation and access (Geiger, 2003). Identification of effective unequal treatment and discrimination in the healthcare system, in particular structural barriers to prevention and care is also considered an important research issue to analyse in further research (Weiss, 2003). Finally, it is worth noting that patient mistrust of care providers (or health treatments) may affect decision to seek care (Smedley et al., 2003). Investigations should therefore assess migrant patients attitudes toward healthcare providers and services, and examine the influence of such attitudes on healthcare systems utilisation. For instance, according to patients of different cultures high reliance on technology to diagnose illness may be less positively perceived than other health assessment skills as touching the body (Van Dongen and Elema, 2001), pulse taking or discussion about the patients relationships and current circumstances (Sung, 1999). Further research should also assess appropriate means of addressing possible negative cultural beliefs about care seeking and mistrust of healthcare services, treatments and providers.

2.3. Understanding life-world of migrants

The delivery of health care in a pluralistic society demands a patient-centred care that takes into account different cultural attitudes, values, beliefs, practices and resources. For instance, culture may affect views about the causes and treatments of illness, when to seek treatment, whom to consult and what treatments are appropriate (Dilworth-Anderson and Gibson, 2000). Research aiming the comprehension of life-world of migrants -in other words theirs health strategies, resources, beliefs and requirements- is especially important for the health care system, to provide adequate prevention and management of health problems, and to better take into account autonomous capacities or health resources (Attia and Marburger, 2000).

2.4. Monitoring

Lack of healthcare data that take into account the diversity of the migrant population is observed in Switzerland (like in other countries), as well as lack of monitoring concerning needs of specific groups of migrants (Chimienti and Cattacin, 2001). It is therefore extremely important to better consider in the future the diversity of the migrant population, and proceed to targeted analysis (Bischoff and Wanner, 2003). The collection and reporting of healthcare information by patient origin (and other relevant variables, e.g. Demographic characteristics, length of stay, legal status) is an important step in monitoring health disparities and progress in eliminating these disparities. In addition, statistical routine concerning health status and level of mortality of the population should include resident migrants (Chimienti and Cattacin, 2001). The collection of data concerning treatment and assistance of migrants (not only in institutions of the public health system, but also among private doctors and institutions of the social system) is also required (Weiss, 2003). Such data is important to identify the most common health problems among migrants and to define priority interventions.

Regularly monitoring health needs (also concerning actions and information)of specific groups or communities of migrants is also crucial in order to improve both health prevention (and promotion) and quality of care. Monitoring the interventions in the health system is also assumed to be very important

(Dreachslin, 1999; Shaw-Taylor, 2002). Efforts should be spend for example in monitoring the adequacy of the quality of care with respect to migrants and communities needs. Research is needed also for monitoring the quality of communication and interaction between care providers and migrant patients (Smedley, 2003), and for a better definition of such quality standards (matching both care providers and patients needs). As it is the most recognised and widely used measure of effectiveness of provider-patient communication and appears to be strongly correlated with quality of care (Donabedian, 1988), patients satisfaction is extremely important to measure. Interventions aiming the improvement of the quality of communication (and interaction) should also be monitored, with respect to patients and providers satisfaction (Smedley, 2003).
Moreover, monitoring of psychosocial treatment and assistance to migrants is considered very important (Weiss, 2003), as well as the adequacy of different concepts of treatment and assistance according to the needs of migrant patients.
As for **epidemiological studies**, need for an elaborated epidemiological research is often mentioned in the literature (Rieken, 2001; Aspinall, 2000), in order to determine prevalence and incidence of psychic and psychosocial problems among different groups of migrants, and to compare relative degrees of prevalence and incidence to those of the population in the countries of origin. Such epidemiological research should integrate the methods of cultural epidemiology (Weiss, 2001; Weiss, Cohen and Eisenberg, 2001), mixing quantitative and qualitative approaches, in order to provide cultural sensitive information about illness experience (patterns of distress), meaning (perceived causes), and associated behaviour (risk related and help seeking) to complement epidemiological rates of mental and psychosocial disorders. Need is also expressed for a deeper epidemiological knowledge at the international level. As Chimienti and Cattacin (2001) have pointed out, further epidemiological studies are also required for the monitoring (and comprehension) of differences in health status between native and migrant populations (e.g. higher prenatal level of mortality among migrant women, health status of women of the new migration, health at work, health of elderly). Finally, qualitative data on specific groups with limited access to healthcare (e.g. illegal migrants) is considered to be extremely important.

2. Training of Mental health professionals: Review

2.1. Introduction

Human beings have moved from place to place since time immemorial. The reasons for and the duration of these migrations put extraordinary stress on individuals and their families. Such stress may not be related to an increase in mental illness for all conditions or to the same extent across all migrant groups. Migration is the process of social change whereby an individual moves from one cultural setting to another for the purposes of settling down either
permanently or for a prolonged period. Such a shift can be for any number of reasons, commonly economic, political or educational betterment. The process is inevitably stressful and stress can lead to mental illness.
The migratory process can be seen as three stages. The first, pre-migration, is when the individuals decide to migrate and plan the move. The second involves the process of migration itself and the physical transition from one place to another, involving all the necessary psychological and social steps. The third stage, post-migration, is when the individuals deal with the social and cultural frameworks of the new society, learn new roles and become interested in transforming their group (see Fig. 1). Primary migrants may be followed by others.
Once they have settled down and had children, the second generation is not a generation of migrants, but it will have some similar experiences in terms of cultural identity and stress.
We must advise a note of caution here. Although we are using the terms 'migrant', 'migration' and 'psychological disorders', these do not explain the heterogeneity inherent within each setting. Not all migrants have the same experiences or even the same
reasons for migration and certainly the new societies' responses are not likely to be similar either.

2.2. Data limitations

Unfortunately any consideration of the relationship between migration and health tends to be limited by the relative paucity of information that exists in some countries on this issue. Few EU countries, for example, systematically or routinely gather information on the health of migrants, and current health recording systems are not designed to identify people by migration status. In some cases the lack of precision as to who is a migrant as opposed to a descendent of migrants makes the task even more difficult, especially where people are defined by region as opposed to country of origin. In other cases, people are defined more by ethnic origin than their length of stay, and refer to children of migrants and migrants as one group irrespective of whether they are second generation and born in the country they reside in. The growing phenomenon of unofficial, and hence unrecorded migration poses another obstacle to understanding the real pace and scope of contemporary movement and all the ways in which population movement affects health and health care. Yet unofficial migration may be even more important a process than official migration in terms of how it affects health.

Various reports on Mental Health Issues Affecting Immigrants and Refugees indicate the need to develop culturally sensitive health care for all citizens . Despite the policy of equal access to care for everyone, significant barriers to care continue to exist for immigrants, refugees and ethnocultural minorities by reason of language, culture and ethnicity. There is a growing awareness of the differences that exist in access to health services between the minority groups and the majority population. Health promotion designed for the general population usually does not reach diverse ethno-cultural groups. The provision of culturally responsive and linguistically appropriate health promotion programs is necessary to address the existing disparities and ensure equal access to all the resources.

Culture shapes the experience and expression of emotional distress and social problems in myriad ways (Kirmayer, 1989). In order to accurately diagnose and treat patients from diverse backgrounds, therefore, it is essential to consider the cultural meaning of somatic symptoms, and explore the social context of distress

(Kleinman, 1988; Mezzich et al., 1996; Rogler, 1993, 1996). A variety of models have been developed to meet this clinical challenge. These range from ethnospecific mental health services or clinics (e.g. an Indochinese Refugee Mental Health Clinic; Kinzie et al., 1980), to the use of culture brokers and specially trained mental health translators, to the training of clinicians in generic cultural competence. Despite the apparent utility of many of these approaches, to date there have been no studies to demonstrate their efficacy and cost-effectiveness. In a climate of constrained resources for health care and steadily increasing cultural diversity, the development and evaluation of models of care has become an urgent priority.

Beyond the need for basic research on models of care for culturally appropriate and accessible mental health services, there is a need to improve the process of diagnosis and treatment in cross-cultural psychiatry (Rogler, 1996). This is not simply a matter of devising a cultural formulation of a case, but requires the development of assessment instruments, new strategies and techniques of intervention and research to better understand the interactional processes of interviewing, interpreting, assessment and treatment in the larger context of the changing demography of our society.

2.3. Cross-cultural training review

Although cross-cultural theory and training initiatives in mental health have their beginnings in post World War II awareness about the atrocities that occurred, and some training initiatives took place as early as the 1960's, it is only in the recent past that the topic of training has emerged as a growing area in need of further definition, clarification and categorization. Training practices reflect not only explicit viewpoints on notions such as race, ethnicity, culture and clinical models for working across cultures, but also contain implicit assumptions and world-views within ideological, social and philosophical frameworks. It is therefore an important step at the current juncture of cross-cultural training practices and standards, to take a step back and clarify the issues and sub-issues that that are inherent in training theories and practice. In a very real sense, the growing number and types of training programs, materials, and curricula can be viewed as an attempt to bring the field of cultural psychiatry, psychology and related disciplines to a level of practical application and everyday relevance for clinicians and clients alike. As well, with the advent of the global village and increasing migration across the world, the need to have coherent conceptual schemas of training and to make explicit the hidden assumptions that lie beneath practices and standards comes to the forefront.

This document aims primarily to present the Minkowska Centre multimedia training module for health professionals. It also contains an overview of the current state of cross-cultural training in the mental health domains. This will be accomplished across a number of levels of theory and current practices. Section one of this document covers a range of topics under the broad scope of theory. Four topics are considered. First, a brief overview of some of the historical factors in the shifting notions of mental illness and the evolution of cultural psychiatry, psychology, and counseling are considered. Second, the philosophical underpinnings of various cultural perspectives and subsequent views on cultural training are considered. Third, various theoretical constructs, definitions and models of training are presented. Section two highlights existing training models, practices and curricula in several domains, across national and cross-national trends. Several questions are of interest in considering the practical and theoretical aspects of the state of training and cross-cultural education within academic and clinical settings in mental health. Some of these include: What are the types and numbers of training programs that exist on a national and cross-national basis? What are the trends and divergences of explicit models and goals in reviewed programs and curricula from cross-national and within national points of view? What are the trends of implicit assumptions and world-views in these models? What cross-cultural issues are well covered and which still need to be developed?

In an effort to address these and other questions, a number of initiatives were undertaken, including an extensive review of the current literature, curricula and programs available in this area.

The last of this document gives specific focus to the paradigms of cultural competence. So overarching is this notion that it can be separated out from mainstream forms of training and educational programs in order to be considered as a movement that coincides and overlaps with training issues, but which extends beyond to overall societal and mental health structures. Included in this area is consideration of the mechanisms for evaluation and research practices.

2.4. Historical Aspects of Cultural Psychiatry and Cross-Cultural Psychology

The history of cross-cultural training in the mental health domains can be traced within the context of the evolution of cultural psychiatry and psychology in general. The history of cultural psychiatry has seen a shift across three stages of conceptual frameworks that involved movement from an initial colonialist phase to a commitment to universality in psychiatry, and finally to the current phase which places psychiatric knowledge and practice itself within a matrix of cultural construction, making itself the object of cultural critique. The colonialist phase was characterized by the imposition of exported health care practices (and systems of classification) onto particular cultural groups and nations, by a kind of "exoticizing" of symptoms leading to notions of specific "culture bound syndromes. " The second phase sought universality in psychiatry by establishing standardized diagnostic measures comparing cross-national prevalence, manifestations, course, and outcomes of disorders. The work of Kleinman (1977) was seen to have ushered in a new phase that brought to the surface the realization that cultural psychiatry itself needs to be the subject of a critical, cultural critique. A new dialogue between anthropology and psychiatry was thus established, paving the way for renewed conceptualizations of notions such as race, culture, ethnicity, and how these may interface with diagnostic models, practice, and training within the mental health domains. As well, the conceptual and paradigm shifts taking place within western epistemological theories, particularly in science-based systems of knowledge, and the recognition of the social construction of previously taken for granted "facts" have all contributed to the current state of critical reflection on the biases inherent in Euro-American notions of the psyche and of ways of being in the world. The critique of the possibility of absolute knowledge has implications for educational practices within mental health disciplines. Despite the clear epistemological and ontological shifts that have taken place in most intellectual domains, there remains concern that reified colonial systems of knowledge bases and teaching structures continue to linger. This may not be by conscious choice alone but worse, may be a result of a lack of clarity about the implicit assumptions in theoretical models and clinical teachings. For this reason it is important to unearth the current strands of thought inherent in various conceptual models of cross-cultural training in mental health and to highlight areas of convergence and divergence.

An earlier paper by Moffic, Kendrick, Loman and Reid (1987) traced the development of cultural psychiatry within the United States along similar lines. They noted the abundance of divergent views on the notion of culture itself and whether it should be understood within psychiatry in broad strokes of connotation, as in any segment of social reality, or only in specific reference to racial, ethnic, or religious minority groups. They trace documentation on the beginnings of training in transcultural psychiatry to a 1968 survey conducted by Jeffress (cited in Mofffic et al.). It was noted that less than 30 percent (n=41) of residency programs surveyed reported any training at all. In 1977, another questionnaire was sent out by the AADPRT with regards to the presence or absence of "Minority/Cultural training in psychiatric residency programs. While 48 programs claimed to have some transcultural content in their curriculum, only 12 out of 110 responses from 220 programs surveyed indicated that they offered a special course on minority/transcultural issues. Reid again conducted another study in 1984 on those same 48 programs and more than 40 percent of the respondents indicated that those "special courses" had been discontinued. Loss of funding and faculty were reasons cited. The authors note that the negative trend in decreasing educational practices in cultural psychiatry, as well as other negative legislative events stood in contrast to what was an overall significant increase in knowledge of cultural theory and practice in psychiatry in general. The authors quote Westermeyer in this regard: "currently our training programs and much of our

clinical practice lag far behind the cross-cultural research findings, and demonstrated diagnostic techniques"(1985, cited in Moffic et al.) Moreover, the programs that were known to exist highlighted a lack of consensus in terms of their curriculum objectives.

2.5. Psychology and Counseling

In a similar vein, Segall, et al (1998) trace the development of cross-cultural psychology and note that as a discipline, it had long ignored the role, or influence, of culture on human behaviour and in general has taken little account of perspectives outside of those which are Euro-American. According to these same authors, the early work in cross-cultural psychology proposed three complementary goals, which included: to transport and test current psychological knowledge and perspectives by using them in other cultures; to explore and discover new aspects of the phenomenon being studied in local cultural terms; and to integrate what has been learned from these first two in order to generate more nearly universal psychology, one that has pan-human validity. Researchers however were confronted with the realization that the search for universals under the guise of a cross-cultural psychology was limited and presupposed a focus on quantitative variables that produced any number of instruments drawn from Euro-American settings and then applied across-cultures. Moffic et al also noted that like the domain of psychiatry, cross-cultural training in psychology decreased in the 1980s but that by the end of the decade another national survey across university programs in the United States indicated that there was renewed interest in this area.

Ponterotto, Casas. Suzuki and Alexander (1995) provide a comprehensive overview of the field of multicultural counselling psychology in their edited, *Handbook of Multicultural Counseling*. Contributor, Morris Jackson discusses the history of cultural considerations within the Counseling domain under the rubric of "multiculturalism". He notes that multiculturalism within Counseling finds its roots in the guidance movement that took place in the industrial towns of the Midwest in the United States in the 1950's. The counseling profession has shown leadership in forging new avenues of discussion in multicultural clinical practice and training. So important has the area of culture become to the counseling profession that Pedersen (1991) referred to it as the "*fourth force*", following the "third force" humanistic tradition. Derrald Wing Sue is another early leader in this field who in the 1970's introduced the concerns of a variety of cultural groups who had largely been ignored in the counseling literature. He is recognized for bringing the notion of *diversity* to the counseling profession. Still, multiculturalism in the guidance movement is thought to be have been plagued by its universal dictum "guidance for all" which instead of living up to an inclusive agenda was fraught with implicit monolithic principles from the Euro-centric intellectual traditions. That is to say, the golden Aristotelian mean maintained its hold on such blue prints as personality, intelligence (testing) and motivational principles. More recently the Counselling profession is seen to have shifted to a more pluralistic perspective illustrated by a questioning of the validity of standard theories and techniques in assessment and practice. In the same volume, Sue, Arredondo and McDavis note that 89% of counselling psychology programs now purport to offer a multiculturally focused course. The danger remains however that such programs may either be conceptually lacking or disorganized. They may be taught by junior instructors, fail to move beyond cultural differences at an intellectual level, or to consider the wider sociopolitical contexts of oppression, discrimination, and racism. To address these inadequacies, the authors propose a series of multicultural competencies and guidelines, which will be duly considered.

a) Philosophical Issues

Several aspects of implicit and explicit training philosophies have been the subjects of discussion in the literature on cross-cultural training. There is growing convergence on a number of philosophical viewpoints as they relate to multicultural, transcultural, or cross-cultural issues. On the other hand, clear

philosophical distinctions can be drawn between inherent beliefs that precede views on the notion culture as well as the values, goals, and purpose of cross-cultural training programs.

b) Race, Culture, Ethnicity

These three constructs form the beginning premise of virtually every training theory or model. There are no definitive definitions or universal agreements on the need for or on the ways of categorizing the human makeup but much progress has been made in bringing to surface the implicit connotations in various definitions, and therefore leading to explicit models of theory and training practices.

c) Race

Green (1995) credits Margaret Mead as one of a group of anthropologists who debunked the assumption that race is either a culture, or exists as a scientific construct or "brute fact". In this sense, race has been established primarily as a social viewpoint relating to how groupings of people are categorized, most notably according to skin pigmentation or other physical characteristics. The essentialist, biological basis of race has also been called into question by the post-modern movement which rejects broad generalizations in favor of more contextualized, local, and historically informed knowledge. However the definition and relevance of the construct of race is far from resolved in that new meanings emerge in the guise of other constructs such as such as class and religion. One author notes that " ‘scientific racism' has given way to cultural racism". (Sefa Dei, 1996) In a paradoxical way then, the notion of race has become a central tenant in one philosophical position on training; namely that intercultural training is essentially about "Race Equality Training" or anti-racism education. (Sefai Dei.1996, Fernando, 1995)

d) Ethnicity

Ethnicity is equally not a clear construct. It begins with the notion of "otherness", as a system of meanings, which by which one makes comparisons. In this sense, ethnicity is not a stable concept and very much a product of self-perception and subjective experience. Green (1995) describes two models of ethnicity in consideration of race, ethnicity, in the context of social services. The first view of ethnicity describes four types: ethnicity as class; as political movement; as revival and as token identity. (Alba, 1990, cited in Green, 1995) The author points out that ethnicity is sometimes associated with class, particularly when it is used to portray working class as an under-class. The second view of ethnicity relates to political process. A group or collective, who have endured oppression in one country and are in another country by virtue of this oppression, forms a basis for a collective identity. A third aspect of ethnicity relates to a deliberate return to one's roots and lost sense of traditions. The final type in this taxonomy is ethnicity as symbolic token. This version relates to a tendency of people to trace the ethnic ancestry out of a kind of nostalgic connection. (See Table 1)

Table 1. Concepts of Ethnicity (Green, 1995)

Type	Characteristics	Examples
As social class	Distinctive lifestyle	Urban and rural Ghettos
Politics	Group mobilization	Ethnic power movements
Revival	Return to traditions	Public and family

		celebrations
Symbolic token	Minimal commitment	Remembered family traditions

Table 2. Components of Ethnicity (Nash, 1989).

Core Elements		**Surface Elements**
Kinship		Living arrangements Family rituals Demographic patterns Descent Physical characteristics
Commensality		Food preferences Sharing patterns Consumption and lifestyle
Belief		Behavioral, speech styles Values, norms Ethnohistory Celebrations

Other approaches to ethnicity described by Green include *categorical* or *transactional* views. The categorical approach, which is still considered the North American norm, assembles portraits of ethnic traits. In this approach, individuals are slotted into a pre-determined set of expected constructs. *Cultural pluralism* is equally a categorical approach but stresses the distinctiveness of ethnic groups, so that a separate but equal philosophy prevails. Transactional approaches in the tradition of Fredrick Barth (1969) reject the surface elements of ethnicity and propose that it is the ethnic boundary, which defines the group and not the "stuff" inside it. In this view, boundaries are loose and context -based, and are an emergent

function of transactional aspect of relationships. (See Table 3) It is evident that any of these constructs of ethnicity have important implications for the framework of training in cross-cultural mental health.

Table 3. Categorical vs. Transactional Views of Ethnicity

Categorical	Transactional
Emphasis on cultural "content"	Emphasis group boundary
Assumes high level of cultural uniformity within groups.	Expect differences within groups
Seeks conceptual simplification in response to cultural "otherness"	Seeks conceptual complexity within a comparative perspective
Assimilation or acculturation are policy and intervention goals	Resolution within indigenous frameworks as intervention goal
Associated with melting pot and pluralistic ideologies.	Anticipates resistance to political and cultural dominance

e) Culture

The notion of culture has been the subject of numerous definitions that are contextually based. A common definition often cited is that of Kluckholn's (1962) which views culture as a dynamic construct constantly reshaping itself. He states: "Culture consists of patterns, explicit and implicit of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiment in artifacts; the essential core of culture consists of traditional (i.e., historically derived and selected ideas and especially their attached values; culture systems may, on the one hand, be considered products of action, on the other as conditioned elements of further action" (p. 73). Other scholars understand culture in a variety of ways

Also, culture cannot and does not mean the same things in all contexts. Within psychiatry, culture is usually seen as something that belongs to the patient. In a more positive view, culture can be used as a frame to understand the particular worldview and set of circumstances that a patient may be come from. The most helpful use of the notion of culture in their terms recognizes that psychiatry itself is the product of a cultural world.

Brislin (1990) and Sue and colleagues (1982) are among those who view culture as a meaning system that usually takes place within a geographic boundary. Culture can also be viewed in broad or specific terms. Gopaul-McNicol and Brice-Baker (1998) take a broad view, and define culture as "a way of living that encompasses the customs, traditions, attitudes, and overall socialization in which a group of people engage that are unique (not deficient) to their cultural upbringing."

The centrality of the notion of culture to training practices and the diverging views on what constitutes culture has led one group of scholars to devise a typology of philosophical assumptions in multicultural counseling and training. Philosophical assumptions underlying multicultural training (within the U.S. for example) can be grouped into five types (Carter and Qureshi, 1995). These are universal, *Universal, Ubiquitous, Traditional, Race- Based and Pan-National*. (See Table 4*):*

Universal. The universal or etic approach maintains that all people are basically the same and that intra-group difference is greater than inter-group differences.

Ubiquitous. The ubiquitous approach is considered a liberal position. In this view all forms of group identity or shared circumstances are considered as culture. The assumption is that any human difference should be considered cultural. This would include disabled people, gay people, etc. The main idea of this approach is that people suffer psychological consequences of being perceived as 'different' and training should focus on overcoming notions of difference by empathic understanding and 'celebration' of their point of view.

Traditional. The traditional view embraces the notion that culture is largely a reflection of country, language, history, values, beliefs, rituals, etc. The assumption is that shared background is the basis of culture.

Race-Based. The race-based understanding of culture accepts the notion that culture is a function of race and ethnic background. It places race at the forefront of significant difference between people and maintains that it supercedes all other experiences. Proponents of this view hold that racism and racial identity should be at the main focus of cross-cultural training.

Pan-National. The pan-national approach to training is based on the philosophical view that European psychology has oppressed, dominated, and discriminated against people of African, Asian, and Indian background. It attempts to teach trainees to grasp the fundamental flaws of Eurocentric psychology and to re-situate themselves within a new context of global understanding.

Table 4. Multicultural Training Approaches: (Carter & Qureshi, 1995)

Model	**View of Culture**	**Approach**	**Goal**
Universal	People are basically the same; intra group differences are greater than inter-group	Affirm human similarities; focus on shared human experience	Transcend construct of race
Ubiquitous	All loci of identity or shared circumstance are constitutive of culture; people can	Make counselor comfortable with difference; foster cultural sensitivity	Acknowledge and celebrate difference

	belong to multiple cultures		
Traditional	Culture equals country: determined by birth, upbringing, and environment and defined by common experience socialization and environment. Race as social construct is ignored	An individual's circumstances are superceded by the general culture, cultural membership circumscribes possible personality dynamics	Trainee should experience new culture through exposure; use of cultural informants.
Race-Based	Race is the super-ordinate locus of culture; experience of belonging to a racial group transcends all the experiences; culture is a function of values of the racial group	Racial Awareness recognizes the effect of racism and oppression, and foster racial identity development for all racial groups.	Trainee should learn about racism and their own racial identity development.
Pan-National	Culture is a function of a dynamic other than geo-social; racial group membership determines one's place in the distribution of power; culture is viewed globally	Teach about the history of racial-cultural groups dating back to ancient times. Students should know the psychology of oppression and the history of imperialism	Teach trainees about how psychology of oppression and domination influences counseling process

		and colonialism.	

2.6. The Etic-Emic Debate: Complement or Contrast?

The *etic* and *emic* perspectives are seen as crucial frames or markers of comparison by which approaches in the field of cross-cultural training can be situated. Bhawuk and Triandis (1996) consider the centrality of these constructs in the application of cross-cultural training approaches. Etic and emic perspectives are delineated as constructs that in the first instance focus on "the natives point of view" and in the second place emphasis on the scientist's point of view. The term etic has also been applied in contrast to emic to refer to (a) comparative, cross-culture studies and (b) internal exploration of psychological phenomena in local cultural terms. This re-framing of cross cultural research was intended to allow for a ‘ derived etic' to emerge in place of an " imposed etic. Emics are seen as essential for understanding a within view of a culture but an etic, perspective is seen to allow for cross-cultural comparison. Two approaches for the study of similarities and differences between cultures are also noted. The first approach begins with a construct generated in one's own culture and applied in another (imposed etic). The observer or scientist makes note of how this construct changes in that culture and therefore a derived emic comes to the surface. A second approach supported by Triandis (1996) entails that a construct is first evaluated by a group of researchers from across cultures. In this instance, the etic and emic aspects of the construct are identified and measured by locally validated construct. Emic and etic perspectives are important beginning premises of training programs and help situate a training philosophy in regard a culture general, culture specific or integrated approach.

Absolutism, Relativism, Universalism

Three concepts related to the emic, etic debate are the notions of absolutism, relativism, and universalism. Berry, Poortanga, Segall, & Dasen (1992) posited three theoretical orientations in cross-cultural psychology. *Absolutism* assumes that human phenomena are basically the same across all cultures. In this view, mental illness and psychological phenomenon in general, are seen to be genrealizable across cultures so that, depression, for example will be manifested in similar ways across cultures. The notion of culture is thought to play little if any role in the manifestation of human characteristics. This orientation approximates an imposed etic. Cultural relativism stands in juxtaposition to absolutism and was enlisted as an anthropological concept to support the view that cultures are contextually based and should not be cross-compared. In reality these two concepts serve as poles along a continuum with researchers and theorists placed at differing points. A third concept in this spectrum is that of universalism. This notion views human experience along universal lines and assumes that there are certain basic human characteristics in which all humans share. These can be considered specific psychological givens, which may be influenced by contextual, cultural variables or what are referred to as "variform universals."

Individualism-Collectivism

The concepts of individualism and collectivism are also tied into the above mentioned notions but serve to give particular emphasis in another direction. Triandis, Brislin and Hui (1988) explore these concepts as a major dimension of cultural variation and suggest that they may provide a way by which cross-cultural training can be framed. They note that these world view concepts serve to situate a group or person with regards to their life focus on individual or collective needs. They were highly researched, by Hofstede (1980) on an extensive cross-national study and provide a sound basis by which cultural (and individual)

differences can be compared. These two concepts serve to situate cross-cultural comparisons on major dimensions of personality and societal world-views. Briefly stated, collectivist individuals or cultures are people who subordinate their personal goals to those of the collective. In this view the self is understood in terms of a collective and thus as part of the group culture of the family, nation or community. Individualist societies on the other hand tend to place emphasis on the self as autonomous and the primacy of individual rights and personal goals. Individualism is thought to predominate in northern and Western Europe and in North America. Collectivism is thought to be common in Asia, Africa, South America, and the Pacific. However, differences within cultures are also noted. Triandis et al provide a 23 point list of the characteristics of individualism and collectivism along the lines of notions of the self, activities, attitudes, values, and behaviors, of which may be used as a philosophy and model of training.

2.7. Models Of Training

The variety of perspectives and philosophies discussed above give rise to a number of explicit conceptual training models that have been implemented in a variety of contexts. These are presented below and considered under general and categories. Specific models of training such as curriculum design and content will be considered further on.

Cultural /Anthropological

The work of Arthur Kleinman (1988) ushered in a new era within cultural psychiatry by establishing a link with anthropology and psychiatry. These developments have served to re-contextualize the notions of mental health and illness within a cultural context through culturally informed explanatory models of emotional, physical and psychological experience. Training programs under this domain are most notably attached to university environments within departments of psychiatry, and anthropology. The Cultural Formulation now contained within the DSM 1V is one of the fruits of the introduction of anthropological concepts into diagnostic nosology.

Clinical

Clinical training models most notably predominate in the United States and Australia. Programs that have a clinical training emphasis are considered to be a patient based approach and are often attached to hospitals under residency curricula or clinical requirements of psychology programs. (Castillo, 1997) The emphasis of training in this area is on topics such as the cultural formulation, use of interpreters, developing cultural sensitivity and awareness, communication issues, counter-transference issues, knowledge about specific cultures and populations, including epidemological information and informed supervision. (Foulks, Westermyer, & Ta, 1998; Moffic et al., 1987; Zatnick & Lu 1991; Lu and Mezzich, 1995; Carillo, Green & Betancourt, 1999)

Several sub-types of models have emerged in the clinical training domain. Some of these include the following: culture broker, cultural competence, culture expert ethno-psychiatry, and developmental perspectives.

Culture Broker

The notion of a culture broker originated in anthropology and has been used in cross-cultural clinical and training settings. In this instance a member of a particular cultural community acts a trainer or clinical intermediary between clinician and client. Other variations of this model include "team-wide strategies" where each member of a team takes on a liaison role with a cultural community and is the educator for the

team. Another variation is establishing a "community committee" as advisors and a liaison group (Bhui & Bhugra, 1998).

Cultural Competence

Cultural competence can be regarded as a specific clinical model. It is also a general model in the sense that it addresses several levels of cultural interventions and training at the individual, organizational and policy levels. On a clinical level cultural competence is generally defined as the acquisition of competence under three main headings that include beliefs and attitudes, knowledge, and skills. Each of these areas is operationally defined with strategic guidelines in an attempt to address change at a behavioral level. The cultural competence model of training seeks to make explicit objective requirements and outcomes that would give evidence of increased culturally competent mental health care. Cultural competence could be considered a behavioral approach in its attempt to promote observable and measurable interventions. It does not focus on implicit levels of racism or cultural awareness but rather, operates on the principle that changes in attitudes and ideas can be implied through behavioral change. Cultural competence models have also tended to support the view that cross-cultural training should entail knowledge about specific cultural groups and tacitly or explicitly promotes culture specific mental health services. This model will be considered in more detail in a subsequent section of this report.

Ethnopsychiatry

Ethnopsychiatry is a discipline within psychiatry which considers cultural identity (cultural space) to be as important as the psychic function within a person. Based on the more recent work of Tobie Nathan, and Marie Rose-Moro, ethnopsychiatry promotes an ecological understanding of mental illness and health within the contextual factors of a given culture. (Moro, 1994) As such, ethnopsychiatry employs a psychodynamic, symbolic understanding of the internal world of the individual within a further cultural overlay. It promotes treating migrant families within their cultural values and concepts of illness and healing practices. This tradition has gained increasing recognition over the last fifteen years in France, and is also a current strand of clinical and didactic approaches in Montreal. Training in this approach is offered at the *Centre George Devereux for Psychological Help for Migrant Families*, in Paris (Freeman, 1997).

Clinical —Anthropological

Another group of academics in the field of cultural psychiatry attempt to bridge the anthropological and clinical approaches. Armanda Favazza is one clinician and academic who maintains that there must be some basic conceptual training in addition to a strictly clinical focus. In his view culture overarches, informs, and gives meaning to psychology, biology, and social processes. In these terms culture is not only something one thinks about when dealing with patients of a various ethnic backgrounds."

Cultural Epidemiology & Sociological Models

This model combines epidemiology and anthropology in order to measure the impact of culture or illness experience, meaning and behavior and the occurrence of cultural determinants in course and outcome. It therefore focuses on the national, cross-national and cross-cultural patterns of mental illness and resilience in the context of migration, immigration, and refugee populations. Javier Escobar (2000) and Pedro Ruiz, (2000) are two academics who represent this focus and have worked extensively in this area. Another approach, integrating sociological perspectives, is demonstrated by the work of Loyd Rogler at Fordam University.

An approach developed by Mitchell Weiss and colleagues at the *Swiss Tropical Institute* incorporates an integrative framework for cultural epidemiology whereby these two disciplines are combined in order to understand the impact of culture on illness experience, meaning and behaviour. (Swiss Tropical Institute Report, 1999-2000) The EMIC instrument developed by Weiss, one promising tool that has been developed whereby culture, meaning and behavior can be understood and integrated through gaining an understanding of the insider's point of view and narrative accounts.

Anti-Racism or Race Equality Training

A fourth approach; one that pre-dominates in the UK, is an anti-racism model. (Fernando, 1995) The approach avoids a focus on culture per say, in favor of a training paradigm based on unearthing and understanding various forms of racism and oppression within the mental health systems. The basic premise of this model is that inequality and age-old colonial oppression are the root problems within mental health services in how ethnic minorities are treated and understood. This model thus places emphasis on things such as the importance of societal values in diagnosis and treatment, the power dynamics between professionals and service users, and institutional forms of racism. The goal of race-equality training is to question western-based assumptions in medicine and to re-orient the health worker to consider other value systems and paradigms of health and to debunk the myths of colonial health practices and gain political awareness of the fundamental forms of oppression in society.

The Race-Culture Continuum in Training

The observation has been made that most cross-culture training places itself somewhere on a continuum between anti-racism training and knowledge about cultural groups. At one end of the continuum, some programs and teachers proffer a strict anti-racist approach in the goals and application of their curriculum. At the other end, programs may only focus on cultural sensitivity, cultural difference of cultural knowledge across groups. As well, some programs may claim to be more at one end of the racism, and culture continuum but are actually at the opposite end according their implicit and naively explicit curricula. Much of the confusion can be traced to conflicting or contradictory applications of the notions of race, ethnicity and culture.

The Integration Model

In this model, diversity content is integrated into the overall training curriculum (D'Andrea & Daniels, 1991).

Developmental Model

Training emphasizes stages of learning in the process of cultural awareness. D'Andrea and Daniels (1991) describe a model of multicultural education that embraces a developmental perspective. In these terms the program or student can be identified according to a developmental grid which begins at one end of the continuum by a level of cultural encapsulation. Here the person moves through stages of development that begin with an entrenched position and then progresses to stage two, where an awakening occurs. At the second level the clinical training program progresses to a point of conscientiousness. At this point an attempt is made to include cross-cultural content in a program. Stage three progresses to cultural integrity whereby cross-cultural training is incorporated into the didactic, and clinical training components of a program.

Content & Process Based Training

Training can also be regarded according to the degree of emphasis placed on content or process. Training based on content places more emphasis on didactic instruction and culture specific information. Training approaches that focus on process, emphasize experiential learning and self-exploration. This approach tends toward a more general understanding of culture.

2.7. National and Cross-National Trends in Training

One aim of the current paper was to outline and describe the prevalence and types of cross-cultural training in mental health that are currently in practice on a national and international basis. In order to asses this, a number of steps were taken which include: canvassing leaders in this field in North America, Europe, the Middle East, Australia, and South Africa; conducting an internet search of existing programs, web-sites; a review of current published literature in this area; and a cross-national review of various programs, training manuals and curricula. Resulting from this search we were able to gather a portrait of existing programs on a national and international basis. On one level, the current state of cross-cultural training from a cross-national point of view was difficult to assess in that a complete list of programs could not be gathered. One only has to search the Internet to glean the abundance of local initiatives that are springing up in this area. However, what is also apparent is the lack of coherent national schemas of training models. It is as if the left hand is unaware of what the right is doing.

2.7.1. The Cross-National Scene: A Brief Overview

France

France has an established tradition in the model of ethnopsychiatry first conceived by Devereux and more recently developed by Tobie Tathan and Marie-Rose Moro. (See Freeman, 1997) The Center George Devereux at the University of Paris Nord provides training in methods of consultation and mediation for immigrant families. Further, the Migration Sante institution as well as the COMEDE also provide training for health professionals. However the emergence of Minkowska multimedia training module for health professionals and the evolution in designing the multimedia training module for health professionals can be viewed as follows:

- Minkowska centre has gained a broad knowledge in cultural mediation from its field clinical experience
- With an increasingly growing need expressed by healthcare professionals facing difficulties in an intercultural setting in the relationship between the therapist and the patient
- Minkowska Centre elaborated a pedagogical tool for training any healthcare professional to the intercultural setting and relationship, based on the Clinical Medical Approach
- Demands for training are constantly increasing as all the existing models were either focused on culture, language, stigmatizing both patients and caregivers. Such models proved to be incomplete as they did not take into account all the care setting elements such as the clinical importance of cultural and social factors in illness, health and the delivery of healthcare

Canada

The state of cross-cultural training practices in mental health in institutional settings in Canada is at a very early stage. On a formal level, most curricula in psychiatry, social work, psychology have a minimal amount of cross-cultural content and cannot be seen as a yet stable component of these programs. The field of counselling, in general, is more advanced in developing approaches to cross-cultural training and this is reflected in the amount of academic work and publications, which are being generated in this area. Cross-cultural issues are often integrated into university curricula and program focus. (See Ponterotto, 1995; Pedersen, 1999; Pope-Davis & Coleman, 1997) In other domains, we were informed on several occasions that they "used to have a program or that they were only "in the process" of developing one. In one instance, several clinical and academic leaders involved in the field of multicultural education in Ontario collaborated on the preparation of a document that outlined a series of recommendations for inclusive education in medical training at the University of Toronto. However, a program incorporating inclusive or multicultural content has not yet been implemented. (Like et al.1995). On the West Coast, The University of British Columbia has recently implemented a cross-cultural component into its psychiatry residency program at Vancouver General Hospital under the directorship of Soma Ganesan. On the East Coast, The Dalhousie Medical School offers one elective course in cultural issues in child psychiatry. Progress has been made at the level of interpreter training programs and several training initiatives have been implemented across the country, mostly within community colleges. The Alberta Vocational College in Edmonton for example offers an interpreter course aimed at the Medical, Social Services, and Legal domains. As well Algonquin College in Ontario, offers a similar program. (Roat & Okara, 1998) Institutions within Québec have developed or are in the process of developing several initiatives aimed at intercultural training with the health field. At the Université de Montréal, and 18-hour cross-cultural curriculum has recently been developed for medical students. Quebec also represents an exception to the to the otherwise absence of training programs that specifically address mental health concerns. McGill University has a transcultural psychiatry research program offering an M.Sc, in psychiatry under the directorship of Laurence Kirmayer. A cultural psychiatry rotation is also offered for resident psychiatrists. Several transcultural psychiatry units have also been initiated in Montreal, at the Montreal Children's, Jean Talon and the Jewish General Hospitals. In addition the regional council of the health service (MSSS) has developed a training manual aimed towards (general) health professionals as well as an interpreter-training program.

Several hospitals across Canada have implemented multicultural programs that aim to address multi cultural needs of the populations they serve. The Mount Saint Joseph Hospital, for example, in Vancouver has developed a training program manual that addresses multiculturalism at the level of general health care and has established an ongoing training program. Similar efforts are noted in other hospitals across Canada such as the Children's Hospital of Eastern Ontario (CHEO) and the Scarborough General Hospital in Toronto. However, there are rare occasions of programs in effect in the mental health domain. A number of training programs that aim at increasing cultural sensitivity and awareness in health and mental health domains have been generated from community organizations and have been in place for many years. The *Intercultural Institute of Montreal,* for example, has been offering training programs since 1974. Other community initiatives have sprung up in order to address the complex mental health needs of refugee and recent immigrant populations. The Vancouver Association For Survivors of Torture (V. *A. S. T.),* Founded in 1985 is one example of an organization that was initiated by local clinical professionals in order to address the needs of people who have been victims of organized violence. Similar initiatives with a focus on providing mental health services to victims of torture and of training professionals to work with victims have been developed in Toronto and in Montreal (RIVO). The *Canadian Mental Health Association* has also initiated a number of initiatives across the country aimed towards sensitizing community mental health workers to the needs of minority groups. (See Appendix for descriptions)

In summary, it is noted that cross-cultural training in mental health in Canada within major institutional structures is a rare occurrence and what has been implemented is ill defined, undocumented and un-researched. There are informal training structures in place, largely in community organizations, which do not necessarily interact or overlap with government, university or hospital settings.

The United States

The United States has had a limited but active tradition of multicultural education within the mental health domain over the past thirty years. However there has been a growing interest in this area in the last ten years and an abundance of training programs and initiatives have sprung up. Multicultural models and training in the health domains in the U.S. has typically focused on four designated under-served groups including; Afro-Americans, Amerindians, Hispanics, and Asians.

There has also been a growing abundance of mental health programs with a significant cross-cultural focus and a variety training initiatives have developed in this area. Notably, the Universities of Hawaii, California (at San Francisco), and Southern Florida (Miami) are generally considered to offer the best clinical competency training programs in psychiatry. These programs offer clinical rotations in cultural psychiatry within hospital or community settings. The Department of Social Medicine at Harvard University has been an important site for research and training in medical and psychiatric anthropology both for doctoral students and fellows with backgrounds in medicine and clinical disciplines.

Numerous programs have also been developed in the domains of psychology and counselling. In the area of Psychology, the University of Michigan offers a strong program in psychology and cognition which could be considered representative of an anthropological focus in cross-cultural psychology. Western Washington University and Washington State are two universities that offer graduate level programs with an emphasis on cross-cultural counselling. Western Washington State is also home to Center for Cross-Cultural Research.

The United States is also home to the now popular notion of cultural competence. This concept embodies strategic principles, which outline definitions and criteria by which services may be considered culturally competent. It has been defined as follows: "Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, Isaacs, 1989). This definition most often credited to Cross (1989) has led to a flurry of research activities and programs that embrace this principle. Working groups within the mental health domains have been established across the country in an effort to arrive at recommendations for global criteria of cultural competence. *Managed Care Providers* in particular have taken up the cultural competence model at the level of funded research publications. The *National Center for Cultural Competence,* funded by Health Resources Services Administration (HRSA) is one hub of activity in the cultural competence perspective. It is a component of the Georgetown University Child Development Center, Center for Child Health and Mental Health Policy and is housed in the Department of Pediatrics of the Georgetown University Medical Center.

The U.K.

England maintains a strong tradition in the area of cultural psychiatry and has a rich tradition of grass-roots cross-cultural practice and training within mental health. The work done at centers such as Nafsiayt have provided rich clinical models for mental health services and training. (Kareem and Littlewood, 1992) The U.K. in particular, has placed significant emphasis on anti-racism as a corner stone of training practices and established mental health practices as anti-racist clinics and training to promote race equality. (Fernando, 1995) Other clinical community- based organizations such as the QUALB Center have been established

which address specific ethno-cultural needs and that reflect a particular training emphasis on the need for culture specific services. At the formal, academic level, the University College of London offers a MSC program in Culture and Mental Health. The Centre for Medical Anthropology was established in 1989 as an inter-faculty centre within London University. This centre brings together academic anthropologists and clinicians and the departments of anthropology and psychiatry and offers a variety of undergraduate and graduate programmes. Another line of academic study is offered at the *European Centre for the Study of the Social Care of Minority Groups and Refugees.* This centre was established at the University Of Kent within the Tizard Centre, a well-known multi-disciplinary university department. The European Centre was established in 1998 with the aim of encouraging research activity, consultancy, and teaching related to ethnic groups and refugees in Europe. This includes the coordination of a European Masters programme in Migration, Mental health and Social Care for mental health and social care professionals in collaboration with partner universities in the Netherlands and Sweden. The programme is expanding to Southern and Central Europe.

The Netherlands

The Netherlands has a limited but growing interest in the area of cross-cultural training in Mental Health. The recently established joint Masters programme, between the Universities of Utrecht, Kent at Canterbury, and Örebro, in mental health and social care for migrants, refugees and asylum seekers is a good example of the emerging efforts to establish international and cross national training programmes in the field of cultural psychiatry. As well, the University of Amsterdam, in cooperation with the Foundation Centrum has offered a course in Culture, Psychology, and Psychiatry. Centrum has two out patient clinics one of which offers treatment to victims and resistance fighters of the Second World War and the other specializes in treatment of traumatized refugees and asylum seekers. In the domain of Psychology, Tilburg University has a long-standing research tradition in the area of basic psychological processes.

Sweden

In Sweden, most of the training programs have focused on working with migrants in the context of trauma. However a change is in the midst in terms of adding focus on integration and culture. These initiatives are at local level. Within Stockholm, a one-year education program is offered for clinicians working in the area of trauma. The *Karolinska Institute for Public Health Sciences* offers a weeklong doctoral level course in Research Methods and a one-week course in Transcultural Psychiatry are offered to residents. The *Transcultural Centre* started in 1999 with the support of the Stockholm County council, is another initiative, which focuses on "culture" and offers various training programs and seminars to clinicians and an annual course in collaboration with the McGill Division of Social & Transcultural Psychiatry. In terms of emphasis of approach, Sweden has focused on trauma as a mainstay of interventions for a refugee population. However there is now a shift towards other cultural considerations of immigrants and asylum seekers.

Australia

Australia boasts a highly developed spectrum of cross-cultural training programs, which are tied into an apparently cohesive organizational network. The *Australian Transcultural Mental Health Network* provides an example of an attempt to gather a nationally coordinated program under an umbrella network. There are four main partners under this umbrella network. These include the New South Wales *Transcultural Mental Health Centre (Sydney); the Transcultural Psychiatry Unit (Perth); the Queensland Transcultural Mental Health Centre (Brisbane) and the Victorian Transcultural Psychiatry Unit (Melbourne).* In addition, the network maintains an information bank on existing resources and organizations across the country. At the level of academic programs, the *University of Melbourne* offers a

masters in Mental Health Sciences and a graduate diploma in Mental Health Sciences. (Transcultural Mental Health) The overall training approach in Australia is focused on clinical competence and the notion of cultural competence is frequently referred to in the training literature. Minas, (2000) a well know academic in this area in Australia notes, however that the notion of training itself is becoming dated and should be replaced by the term education to incorporate a wider conceptual base. Australia is also home to number of training manuals, which have been produced by the previous partners, mentioned. (See table)

Other Countries

Cross-cultural training in other countries in the world seems to be less developed. South Africa has developed some programs, and the work of Leslie Swartz (1998) at the University of Cape Town in the department of psychology is noteworthy. Israel also has limited cross-cultural training programs in place but has made some local attempts to integrate culture in medical and psychology curriculum. One interesting model recently in place is a method known as "teaching osce". This involves observing simulated interviews and employing a rating system for evaluation.

The Global Perspective

As we peruse through the cross-cultural training efforts that are in existence cross-nationally, we can readily see that some countries are much more developed than others, and that training approaches reflect attitudes, values and general approach of a particular country towards cultural diversity in that nation. Kirmayer and Minas (2000) discuss these cross-national differences towards cultural psychiatry and provide grid by which they may be quickly compared. It is useful, here, to present their diagram with an added category on training approaches. In their model, they note that four broad models of citizenship have been suggested. (Castles and Miller, as cited in Kirmayer and Minas, 2000) These include an imperial model, which brings together diverse peoples under a single ruler; the folk or ethnic model, which defines citizenship in terms of common descent, language, and culture; the republican model, which defines the state as a political community based on a constitution and laws where newcomers who adopt these rules are welcomed as new citizens; the multicultural model which has a republican base but accepts the formation of intact ethnic communities. Such political and historical features of different societies have influenced the directions taken by mental health services and training (Table 5.)

Table 5. Approaches to Cultural Psychiatry and Training

Country	Citizenship	Pattern of Migration	Emphasis in Recent Cultural psychiatry	Models of Service	Training Focus
Australia	multicultural	Immigrant	Language	Mainstream	Clinical /cultural competence
Canada	multicultural	Immigrant	Ethnicity	Mainstream	Clinical-anthropological
England	Imperial or commonwealth	Colonies	Racism	Anti-racist clinics	Race-equality training
France	Republican	Colonies	Traditional Healing	Ethnopsycho-analysis	Ethno-psychiatry

Germany	Ethnic	Guest workers	Culture-bound syndromes, traditional healing	Undeveloped	
Japan	Ethnic	Guest workers	Culture-bound syndromes, traditional healing	Undeveloped	
Sweden	Multicultural	Refugees	Stress and trauma, refuge	Trauma Service	Training in Trauma
United States	Republican	Immigrant	Diversity	Ethnospecific clinics	Cultural competence, under-served populations

(adapted from Minas & Kirmayer, 2000)

There are also training efforts within academic institutions that in a variety of countries.

2.8. Curricula, Training Programs and Cultural Competence Standards

This section will consider various elements of training curricula, programs and cultural competence standards in an attempt to identify and compare the trends, areas of overlap, and methods, of documented programs and course syllabi. Training programs take place in a variety of clinical, academic, and community contexts and a shift in emphasis is noted accordingly. In considering program foci a number of elements can be identified, including aims (philosophy), goals and objectives, program descriptions, methods used, and evaluation.

Ptak, Cooper and Brislin (1995) found that the terms cross-cultural, intercultural, and multicultural are often used interchangeably by trainers. They note that when used precisely "cross-cultural refers to parallel analysis or study of more than one culture, intercultural refers to training between various cultural groups, and multicultural aims to help someone feel at home in more than one culture. As previously discussed the notions of race, culture, and ethnicity are sometimes used in a similar way. These conflated terms sometimes leads to conceptual difficulties in a training curriculum

2.8.1. Aims of Curricula

The aims of curricula in culture and mental health can be divided into two general camps, with many branches stemming from each. One type of curriculum stems from intellectual concerns and is focused on theoretical, social or political foundations of meaning systems in culture and mental health. This approach, usually based in academic settings is more focused on various conceptual models of cross-cultural theory. A second approach emphasizes clinical and practical understandings, methods and intervention styles applied to cross-cultural mental health settings. These two strands are not mutually exclusive and many programs attempt to blend conceptual and pragmatic factors into the didactic curriculum. The shift is worth noting however, because it helps to situate the levels of didactic and clinical focus in teaching or training

mental health workers to think and work in a cross-cultural context. Furthermore it leads to another basic question about cross-cultural training; namely, is cross-cultural training essentially concerned with learning about "the cultural other" in order to appropriately respond to a person within their particular cultural framework, or does it have to do with decoding, and de-constructing the assumptions mental health workers may carry and inappropriately apply to the "cultural other". This slight but significant emphasis turns the venture of cross-cultural training away from the historically dated anthropological practice of "studying the natives" more towards a reflexive study of the observers themselves. Cultural competence models often emphasize gaining an awareness of specific cultures and in this sense are considered culture specific models. Other models attempt to teach the clinician how to apply a basic cross-cultural framework of understanding and treating cultural difference. This is sometimes referred to as a "patient based approach" (Carillo, 1999)

On the whole, a common theme in the delineation of goals and objectives of a cross-cultural training program are those subsumed under a tripartite model based on attitudes, knowledge and skills:

Attitudes. There is general consensus that the starting place in any training endeavor in cross-cultural work begins with the perspectives, biases, values, and prejudices of the trainee. This reflexive attitude begins by a process of self-evaluation that situates ones-self within their own cultural matrix of values, beliefs and customs. Secondly, the training must allow for a (experiential) shift of perspective towards the cultural other in order to understand, respect and validate the others position. In general, then, training programs attempt to intervene at the level of basic human regard.

Knowledge. Training intervention at the level of knowledge is not straightforward. Several models focus on a didactic program that is culture specific according to the particular cultural milieu in proximity. Other models reject this model in favor of more generalized programs based on cultural differences and move towards the notion of teaching the trainee to work contextually and to regard every interaction as cultural. The cultural competence model, in general, has embraced the notion of culture specific expertise as well as culture specific services. Other didactic programs give emphasis to the intellectual, political, and anthropological strands of culture and society.

Skills. All trainers agree that specific cross-cultural skills are required to be clinically competent. These involve culturally competent assessment, treatment, and communication skills.

2.8.2. Curriculum Models

LaFromboise and Foster (1992) describe a variety of curriculum models in cross- cultural mental health. These include:

- *Separate Course Model.* Many curriculums within the departments of Psychology and Counselling offer separate courses in cross-cultural psychology. A survey conducted by Strozier (1990) indicated that 43 out of 49 university programs surveyed, offered a multicultural seminar, 29 of which were required courses.

- *Area of Concentration*. A survey course with further formal course work or exposure to one ethnic group.

- *Interdisciplinary model.* Encourages the student to take courses outside of their discipline in areas such as anthropology or political science. As well, a number of joint programs have been established between departments. Most notably between Psychiatry and Anthropology.

- *Integration Model*. Cross-cultural content is integrated into every course. This approach places the responsibility to implement cross-cultural training practices on the department or training program as a whole.

Minority Recruitment of Faculty and Students

Another important focus of cross -cultural training practices is the question of the institutional strategy to recruit staff and trainers that reflect the cultural context they are situated within. One example of a program that has a proactive approach is a culturally inclusive training program in the Department of Psychology at the University of South Dakota which aims to increase Native American participation in graduate study. The program, called 'Four Winds', attempts to develop a training model that promotes the inclusion of Native Culture and culturally relevant material and approaches to an academic context (Yutrzenka, Todd-Bazemore, et al, 1999). Other efforts have begun to focus on increasing the numbers minority applicants to medical programs, and academic positions within the mental health domain.

Culture Competence Models

A number of cultural competence standards and models have been generated from a variety of sources and domains. There has been much less work, however, in the area of culturally competent mental health care and most researchers admit that it is timely that this subject be undertaken. There are a number of diverse criteria of what constitutes cultural competence. However there is consensus on many major points. One version of cultural competence specifies the major under-served groups within the United States while a more recently evolved version attempts to distance itself from what has been seen as a less inclusive agenda. Gopaul and McNicol (1997) provide a summary of cultural competence criteria, which captures many strands of thinking in other program models. They suggest a fifteen-point schedule of competencies involving elements ranging from treatment, awareness, understanding, language, use of interpreters, assessment, conflict resolution, and research. Other models give focus to institutional competence as well as practitioner competence. The work done at the *National Center for Cultural Competence* in Washington, DC is one example which articulates this model.

3. Questions requiring further discussion

Nowadays, research on the thematic field of migration and health is quite recent and need therefore to be broadly developed. Special effort is to be devoted to interdisciplinary research paradigms and methods (using both quantitative and qualitative approaches), in order to further articulate medical and social sciences perspectives. The emergence of innovative interdisciplinary paradigm, for instance transcultural psychiatry, cultural epidemiology, medical anthropology, is particularly promising, and should be expanded in the future in order to better integrate transcultural research with migration and health research (cf. Weiss, 2003). Our discussion of needed research has contributed to show that further research efforts should be focused on the following thematic areas.

As for the reaction of the healthcare system to pluralistic societies, it is essential to better understand how migrant patients interact and communicate with the entire range of healthcare providers, and how ethnicity and other social factors influence the communication and the care delivery process. Research is required as well to increase knowledge on migrants psychosocial problems, and to improve psychosocial treatment and assistance. A deeper understanding of barriers and disparities in healthcare is also important, as well as the assessment of interventions to reduce

barriers. Further research is needed for a better comprehension of migrants life-world, health strategies, resources, beliefs and requirements, both for valorisation of their autonomous capacities and to provide adequate management of their health problems. Finally, developing monitoring systems on migration and health is considered to be a priority.

Monitoring efforts and epidemiological data should be developed according to international research, in order to favour international compatibility and comparability. In the same vein, research on migration and health should be linked to an international perspective. Research design should comprehend, when possible, comparisons between different groups of migrants, between migrants and the Swiss population, and between Switzerland and other receiving countries. As basic research has to be problem-oriented and particular effort is to be devoted to research valorisation.
Finally, more particularly, from the Minkowska perspective, we propose:

1. In terms of **good practice on the clinical level** the establishment of a Cultural Consultation Service through the training of culture-brokers or cultural mediators involved as interpreters in healthcare contexts with migrants (linguistic skills and being aware of the cultural representations of mental health). This training should also give the culturally specific tools and skills not only to health professionals but to all services working with migrants in order to avoid stigma, both of the migrant and of the caregiver (alongside with multidisciplinary care, case management, community support and rehabilitation services). Experience has showed so far that the effectiveness of healthcare promotion programs addressing mental health and addictions issues depends largely on the way in which they are offered.

2. **Building multimedia** tools for training health and social professionals in cultural competence.

2. In terms of **research, to start an epidemiological survey** based on the EMIC questionnaire (3 or 4 European countries should be associated in this research). This questionnaire avoids ethnical stigmatization and puts the focus on explanatory models of illness.

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