Diagnosing and Treating Mental Illness Across Cultures:

Systemic Racism in Clinical Psychology

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Diverse cultures have historically been underrepresented by psychological research (Arnett, 2008; Nielsen et al., 2017). Using western data and diagnostic criteria designed by western society leads to contemporary understandings of clinical diagnoses and psychotherapies that lack external validity beyond western society. Consequently, when immigrants from these diverse countries seek mental health services, they are disproportionately misdiagnosed and receive psychotherapies that are far less effective. The tools and training that clinicians are provided with do not effectively translate through different cultural lenses. Contemporary diagnostic instruments like the Diagnostic and Statistical Manual of Mental Disorders (DSM) need to include additional representative research to improve their sensitivity across cultures. Furthermore, psychotherapies need appropriate cultural adaptations that connect with cultural minority clients to become properly effective. Diagnostic manuals and empirically supported psychotherapies are culturally biased descriptions of clinical psychology which need cultural competence to accommodate the growing cultural diversity present within Canada and America. This literature overview details the extent of the underrepresentation in western psychological research. Subsequently, it presents a brief account of diverse cultural research demonstrating how mental health expression varies extensively by culture. Finally, expounding on these points demonstrates how the resulting DSM is not adequate for the countries that use it, and the resulting psychotherapies lack efficacy in their populations, perpetuating systemic racism in clinical psychology.

Keywords: Culture, expression, systemic racism, clinical psychology, DSM.

Globalization trends and projections are increasingly diversifying western countries. The U.S. Census Bureau (2017) has estimated that by 2045, non-Hispanic whites will comprise less than 50% of the U.S. population.[1] In Canada, 41.6% of the population are first or second-generation immigrants with 22.3% identifying as visible minorities (Statistics Canada, 2017). As such, cultural awareness is becoming essential for establishments in both the public and private sector. This awareness is paramount in health care to avoid severe misdiagnosis. For instance, people of African descent have a significantly lower white blood cell count, which is essential knowledge when conducting regular checkups or developing effective treatment plans (Reich et al., 2009). Similarly, in mental health care, different cultures display unique symptoms requiring diverse appropriate diagnostics, treatments, and interventions (Bhugra, 1997; Bredström, 2017; Goodmann et al., 2020; Hinton & Patel, 2017; O'Farrell et al., 2020; Zanon et al., 2020). These diverse cultures are severely underrepresented in psychological research, meaning much of the data obtained concerning mental illnesses cannot be properly generalized to diverse populations (Arnett, 2008; Henrich et al., 2010). This creates problems facilitating proper diagnoses and treatments. Clinical psychologists must expand diagnostic criteria, psychotherapies, and research to be cross-culturally representative to accurately diagnose and treat clients not identifying with western, educated, industrialized, rich, and democratic cultures. More specifically, psychologists need culturally competent revisions and additions to diagnostic manuals and treatment protocols to appropriately recognize and treat mood disorders.

This literature review investigates the severity of the aforementioned issues. Furthermore, this overview reveals how underrepresentation in research leads to improper diagnosis and psychotherapy in racialized populations. Countless western societal institutions are systemically inadequate for people of diverse cultures, which keeps the dominant culture at an unethical advantage throughout life (Morgan et al., 2018). This overview exposes how the field of clinical psychology contributes to systemic racism in North America.[2]

To preface, it is important to appreciate what institutions these arguments are addressing. The focus is specifically towards the modern Canadian and American context where the main diagnostic manual is the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA) (American Psychiatric Association n.d.; Paniagua, 2018). The DSM-5 is primarily used in Canada and America, whereas the International Classification of Diseases (ICD) published by the World Health Organization is typically used internationally (American Psychiatric Association n.d.; Paniagua, 2018). Nevertheless, the DSM has become an international standard for research and there are efforts to further align editions of the DSM and ICD (American Psychiatric Association, n.d.; Bredström, 2017). Therefore, although criticisms in this overview are aimed at the DSM for the North American context, its influence on the international stage should not be underestimated.

Underrepresentation

Arnett (2008) analyzed six reputable American Psychological Association journals representing established disciplines in psychology. He revealed the magnitude of psychological research sourced from western, educated, industrialized, rich, and democratic (WEIRD) samples. A dominating 96% of all sampled participants across the publications between the years 2003-2007 came from a WEIRD culture (Arnett, 2008; Henrich et al., 2010). In fact, 82% of all participants were specifically from the UK, Canada, Australia, New Zealand, or the US; the US alone being 68% (Arnett, 2008). Furthermore, over two

[1] Non-Hispanic white is a term used by the U.S. Census Bureau to refer to people who identify as white and are not from Mexico, Puerto Rico, Cuba, Central or South America (2019).

[2] Also known as 'institutional racism', describes when societal systems and practices reduce access to opportunities based on race (Morgan et al., 2018). Where 'systemic' is defined as "fundamental to a predominant social, economic, or political practice" (Merriam-Webster, n.d.-a) and racism, "the systemic oppression of a racial group to the social, economic, and political advantage of another" (Merriam-Webster, n.d.-b).

thirds of participants were undergraduate psychology students (Arnett, 2008). Even within a country, undergraduate students only represent a narrow socioeconomic status and education level making the majority of psychological research ungeneralizable to a global and cultural scale. Researchers like Arnett (2008) posit that psychology should not consider itself a human science when its samples only culturally represent 5% of the world.

More recently, Nielsen et al. (2017) conducted a follow-up study analyzing the top three most influential developmental psychology journals by impact factor between the years 2006 and 2010. In congruence with Arnett (2008), Nielsen et al. (2017) bluntly explains that of the 1,582 papers, 3% of participants represented 85% of the global population living in "Central and South America, Africa, Asia, the Middle East and Israel" (Nielsen et al., 2017, p. 34). They also reviewed papers from 2015 and similarly found that almost 93% of participant data came from WEIRD sources, showing little to no improvement in a decade (Nielsen et al., 2017). This demonstrates that despite increased awareness, there is a lack of evidence suggesting that research is being culturally expanded, perpetuating the issue of underrepresentation and leading to inappropriate methods for diagnosing and treating mental illness in diverse populations (Bhugra, 1997; Bredström, 2017; Goodmann et al., 2020; Hinton & Patel, 2017; Zanon et al., 2020). Psychological data is largely gathered from WEIRD sources which are then responsible for informing the diagnostic criteria in the DSM-5 and other instruments related to measuring mental health. It should not be assumed that the data that informs these diagnostic manuals can be generalized to all populations for diagnosis and treatment. Countries as diverse as Canada and the U.S. must provide mental health services that adequately accommodate the needs of the growing non-WEIRD populations. More research and training are required for clinical psychologists to understand, recognize, and treat cultural expressions of mental disorders.

Symptomatic Differences Across Cultures

There are inherent differences in the way various cultures display, describe, and experience symptoms of mood disorders (Goodmann et al., 2020; O'Farrell et al., 2020; Zanon et al., 2020). According to the DSM-5 there are variations of behavioural and emotional criteria that must be met in order to be diagnosed with a mood disorder (American Psychiatric Association, 2013). Symptoms of depression, for example, are primarily related to feelings and emotions such as depressed mood, diminished pleasure, feelings of guilt, and worthlessness. These diagnostic criteria have empirical support in western populations. However, research comparing symptoms cross-culturally has shown that the criteria is not universally applicable (Goodmann et al., 2020; Kleinman, 1977; O'Farrell et al., 2020; Ryder & Chentsova-Dutton, 2012; Zanon et al., 2020).

The somatization of mood and anxiety disorders is a well documented but poorly understood phenomenon that refers to physical expressions of psychological illnesses (Kleinman, 1982). Research in Chinese populations has demonstrated a tendency to experience and primarily describe somatic symptoms such as muscle pain or fatigue for mood disorders (Kleinman, 1982). In Kleinman's (1982) ground-breaking study on the topic, he observed a sample of 100 patients in China that had been diagnosed with neurasthenia. This currently controversial diagnosis listed in the DSM-II and ICD-10 was characterized as the 'exhaustion of the central nervous system', and related to fatigue and burnout (Cheung, 1998). Neurasthenia was a more culturally acceptable diagnosis at the time, particularly in China, because it was a disease of the nervous system emphasising somatic symptoms, as opposed to a strictly psychological disorder with cultural stigma. Kleinman's review found that 87% of the patients diagnosed with neurasthenia could also be re-diagnosed with depression, according to the DSM-III (Kleinman, 1982). Given China's low rates of reported depression, Kleinman and other researchers hypothesize that it gets conflated with other physical illnesses such as neurasthenia. This is due in part to the somatization of symptoms that are poorly accounted for by psychiatric diagnostic criteria (Dere et al., 2013; Kirmayer & Sartourius 2007; Kleinman, 1982). Different manifestations of symptoms and culturally different ways of communicating these symptoms, demonstrates the difficulty in

diagnosing depression cross-culturally.

Similarly, Lehti et al. (2009) conducted a qualitative study interviewing Swedish general practitioners (GPs) about their clinical experience in recognizing depression in patients from the Middle East and Eastern Europe. GPs are forced to develop intuition anecdotally as "diagnostic manuals gave little backing [and] screening-instruments, sometimes recommended and used, were not regarded as suitable for these patients" (Lehti et al., 2009, p. 5). The GPs elaborate by explaining that bodily symptoms, physical pain, or alcohol abuse can be common indicators of depression in this demographic, albeit not mentioned in the DSM-5's diagnostic criteria. Verbal and non-verbal communication of pain and distress varies by culture, resulting in increased confusion and further complicating signs that typically serve as indicators for GPs to shift their diagnosis to mental health, as opposed to bacterial, musculoskeletal, or otherwise (Lehti et al., 2009). The GPs are criticized by their national authorities for missing diagnoses, yet the standardized screening scales and national guidelines provided are not adequate for these populations (Lehti et al., 2009). Cultural differences in communication styles further exacerbate this problem (Lehti et al., 2009; Zanon et al., 2020). A practical example of clinical miscommunication is with the word '*dépression*' in Haitian Creole which differs from the western understanding of depression (Pierre et al., 2010). The word *dépression* in Haitian culture refers to feeling empty, distractibility, fatigue, and poor appetite, which can be attributed to anything from anemia, a fixation on stress, or even a curse (Pierre et al., 2010). Zanon et al. (2020) studied cultural communication on a macro level by testing the reliability of the Depression, Anxiety, and Stress Scale-21 across eight culturally diverse countries. They concluded that although the scale is used as a research standard, they could not find support that it reliably scored depression, anxiety, or stress across cultures. Likely due to culturally diverse biases, response style, and familiarity with western survey formats (Zanon et al., 2020). Thus, more culturally competent resources must be made available for such variances in communication.

These culture-specific examples are not only observed internationally. Even immigrants who are established in North America, and second-generation immigrants, exhibit many culture-specific symptoms and experiences throughout their lifetime (Misev & Phillips 2017; Wang 2019; Wong, 2017). An *'ataque de nervios'* is a culture-specific mental health syndrome that is most experienced in Latino cultures. It is characterized as short episodes of intense emotions, lack of physical or mental control, fainting, and dissociation (Hinton & Patel, 2017; Wong, 2017). Using extensive survey data, contrary to the hypothesis, Wong (2017) found that second and third generation Latino immigrants in America reported an increased likelihood of experiencing an *ataque de nervios*. Corroborating this phenomenon is Wang's (2019) study, where they found that Asian American second-generation adolescents were significantly less likely to seek mental health services compared to their peers. Wang's study detailed that these findings are heavily influenced by the parental views of western mental health care which inevitably get passed down to children. It is disingenuous for clinical psychology to assume that acculturation will eventually correct for the lack of cultural sensitivity put into research, the DSM, and psychotherapy.

APA's Responses to Criticism

The APA is not oblivious to research on cross-cultural expressions of mental disorders and has implemented revisions and sections that claim to have dealt with cultural disparities. The proposed solutions and culturally relevant sections in the DSM-5 include three main sections. There is a brief dialogue of culture-specific expressions of symptoms under some disorders, an appendix on cultural concepts of distress previously named 'culture-bound syndromes', and a guided interview section on client-clinician cultural formulation (American Psychiatric Association, 2013). These revisions and additions are supposed to provide clinicians and researchers with adequate tools to appreciate mental illness across cultures within the DSM-5.

The dialogue highlighting culture-specific expressions, found under some disorders, typically adds various symptoms that are often recognized in foreign samples.

For instance, under the diagnostic criteria for panic disorder, the APA further lists 'culture-specific symptoms' including "tinnitus, neck soreness, headache, uncontrollable screaming or crying" (American Psychiatric Association, 2013). In the section on major depressive disorder, there is a disclaimer explaining the possible underdiagnosis in diverse cultures, also mentioning the common somatization of symptoms (American Psychiatric Association, 2013). The section goes on to indicate that 'insomnia' and 'loss of energy' are the most consistent official criteria across cultures (American Psychiatric Association, 2013).

In the appendix of the DSM-5 entitled 'Glossary of Cultural Concepts of Distress', psychologists can find narratives specifying local names and concepts for mental illness amongst different ethnic groups. Some examples they provide are '*dhat* syndrome' in southeast Asia, '*maladi moun*' in Haitian culture, and the term '*nervios*' in Latin America, for a total of nine examples (American Psychiatric Association, 2013). The appendix details what these terms of distress mean to an individual from that culture, and what DSM disorder they can relate to. This section was previously known as culture bound syndromes.

Lastly, the cultural formulation consists of a guided interview that is supposed to take place with patients to learn about their background and to relate their explanations of distress to the clinician (American Psychiatric Association, 2013). This section contains culturally relevant sample questions that the therapist can ask to develop an understanding of their client's mental health experience. The interview is accompanied by explanations regarding the reasons and goals for each question (American Psychiatric Association, 2013). These steps demonstrate that the APA has attempted to include adequate resources in the DSM-5 to avoid issues in cross-cultural diagnosis.

While these sections show improvement, they suffer from many inherent shortcomings. For instance, the short paragraph on culture-specific expressions following the 'official' symptoms is concluded by the statement, "such symptoms should not count as one of the four required symptoms" (American Psychiatric Association, 2013). This defeats the purpose of listing culture-specific symptoms because they are not acceptable for diagnosis. The diagnostic criteria in the DSM-5 is therefore only representative of the small percentage of the worlds population that has developed in a WEIRD culture. When symptoms of outside cultures are ignored, the overwhelming majority of the world is ignored, as over 85% of the global population remains virtually excluded from psychological research (Arnett, 2008; Nielsen et al., 2017). Listing symptoms representative of these underrepresented cultures, and then undermining their validity for diagnosis is counterproductive and diminishes their value, such racist language needs to be removed. Furthermore, the DSM uses rigid generalization such as 'Latin Americans' or 'Vietnamese' (American Psychiatric Association, 2013, p. 211), when it could benefit from using a more broadly intersectional lens to approach diagnosis (Bredström, 2017).

The 'Glossary of Cultural Concepts of Distress' in the appendix, previously known as 'culture-bound syndromes' is defined as "collective, shared ways of experiencing and talking about personal and social concerns" (American Psychiatric Association, 2013, p. 758). Ironically, that new definition seems to describe why 'regular' disorders are classified and categorized in the DSM at all. That is to say, all disorders characterized by the APA provide a collective understanding of a psychologically relevant concern, so why separate these ones in an appendix? Bredström (2017) criticizes the section on culture-bound syndromes' placement in an appendix, which makes them seem as 'other' and separate from the 'western' DSM disorders. The DSM is a manual contrived of its own culture-bound data and disorders, but instead of separating western cultural influence, it has become the standard. Moreover, disorders primarily found in western culture, like anorexia nervosa (Banks, 1992), are not listed under the appendix as 'cultural concepts of distress', doing so would be offensive and diminish the legitimacy of the illness (Bredström, 2017). Treating the distress of differing cultures as though they are separate perpetuates the problem. The pervasive labeling and racializing of 'other' cultures without any mention or distinctions for

western culture insidiously exposes the cultural biases present throughout the DSM-5 (Bredström, 2017). Watters (2013) points out that any omissions and placements in the DSM are of utmost importance, as it inadvertently governs everything from insurance coverage to legal ramifications (American Psychiatric Association, n.d.). Furthermore, it is disappointing that an appendix specifically referencing culture-bound syndromes was only able to include nine options to represent the rest of the world. The DSM requires improved cultural competency that addresses these mischaracterisations. Although these criticisms are specifically towards the DSM in the North American context, it is worth mentioning that many researchers have claimed the ICD-10 is arguably inferior to the DSM-5 concerning the emphasis of cultural considerations (Paniagua, 2018). These symptoms of systemic racism are seen globally.

Some would further argue that the DSM is made by western culture, for western culture, and should not have to be universally applicable throughout the cultures of the world. Further, if it studies its own people, and is only primarily used in Canada and America, it should be accurate enough for the culture it was made for. This short-sighted argument fails to appreciate the continual diversification of western countries that was addressed in the introduction. That is, almost half of Canadians were either not born in Canada or have parents who were not born in Canada (Statistics Canada, 2017). Furthermore, even for first- or second-generation immigrants who have lived in a new culture for many years, psychologists should be careful not to overestimate the acculturation of these populations. There are many systemic reasons that those minority groups are not being included in psychological research even though they live here. Minorities are typically underrepresented in societal institutions that may have language, financial, or educational barriers. Perhaps a new immigrant's previous education is not recognized in Canada and they are forced to take a lower paying job, and they are unable to pay for their children's university fees. With 67% of psychological research coming from undergraduate psychology students (Arnett, 2008), minorities do not have a representative chance to participate. It is not enough to say that American research should apply to all Americans, without looking at which Americans are truly being researched, and the significant percentage that are left unaccounted for. This is especially important for the DSM-5 which the APA claims to be a globally "authoritative guide to the diagnosis of mental disorders" (n.d.).

Psychotherapy for Ethnically Diverse Clients

After appropriately diagnosing a mood disorder, the clinician needs to provide appropriate treatment. An effective and common therapy for a variety of mental disorders is cognitive behavioural therapy (CBT). Nevertheless, when administering research-based practices of CBT, the same underlying issue prevails. As per their training, psychologists are administering therapies that have empirical support in WEIRD samples and assuming its efficacy for all clients (Bhugra, 1997). This may explain the disproportionately high therapy drop-out rate, and medication non-adherence rate among minorities in western countries, as when a client is not connecting with a therapeutic approach, they are unlikely to be motivated to continue (Bhugra, 1997). Research indicates that although CBT has some positive effects in non-WEIRD samples, it has been shown to be up to 4 times more effective when the treatment is culturally adapted to the client's cultural context (Benish et al., 2011; Crumlish & O'Rourke, 2010; Griner & Smith, 2006). These meta-analyses all found that culturally adapting therapy resulted in more effective treatment for mood disorders and PTSD (Benish et al., 2011; Crumlish & O'Rourke, 2010; Griner & Smith, 2006). In some instances, culturally adapted therapy meant placing a therapeutic emphasis on the somaticized symptoms often experienced in different cultures, demonstrating the therapist's understanding of the disorder is synonymous with the client's (Hinton et al., 2005). In others, it meant using culturally appropriate language, explicit beliefs, and known values (Griner & Smith, 2006). Cultural adaptation increases the positive expectancy of clients by using culture-specific communication styles and employing culturally appropriate CBT technique adaptations (Hinton & Patel, 2017).

Positive expectancy is crucial in therapeutic relationships as a client will be less likely to contribute the required time and energy into therapies they do not expect to work (Woodhead et al., 2012). The way to develop positive expectancy, however, significantly varies depending on the client's own belief and understanding of their problem, which is often informed and heavily influenced by culture (Hinton & Patel, 2017). For example, traditional Cambodian cultures do not typically refer to 'anxiety' or 'depression' as an illness, instead they use language such as 'thinking a lot' or 'working past one's energy stores' which can lead to dizziness and onset of a *khyâl* attack (Hinton & Patel, 2017). Latino cultures often believe that when limbs get shaky or the mind races it is a problem with nerves, or an *ataque de nervios* (Hinton & Patel, 2017). If the psychologist tells these clients that they will treat them for anxiety or depression, positive expectancy is significantly decreased as the client does not believe they have anxiety or depression, but rather a problem with nerves or an overexertion of energy. Similarly, a Chinese patient may be more willing to seek treatment for "the headaches clouding their mind" but not for depression (Kleinman, 1982). The clinician needs to acknowledge the client's symptoms and cultural understandings of the disorder and explain that their treatment will address their symptoms of dizziness, headaches, or fatigue. This strategy of clearly addressing the patients primary concern and belief increases positive expectancy (Hinton & Patel, 2017), which in turn decreases attrition and increases adherence (Bhugra, 1997). Correspondingly, the CBT techniques used must be culturally salient. For a Latino client with similar symptoms, an intervention could induce dizziness by spinning, and pair it with a more culturally positive activity, such as imagining the piñata game (Hinton & Patel, 2017).

Just as a client's communication style can lead to misunderstandings, so can the clinician's. Culturally adapting communication styles can be, for example, developing a knowledge of proverbs, sayings, or analogies used in that culture (Hinton & Patel, 2017). Many of these culture-specific figures of speech have therapeutically relevant morals, such as anger regulation, seeking help under stress, or expanding focus. These strategies increase therapeutic alliance and culturally relevant communication, promote positive affect, and increase the client's cultural self-esteem (Hinton & Patel, 2017). Some practical examples of this are, the Cambodian proverb 'If you don't become angry 1 time, it gains you 100 days of happiness' to encourage temper regulation; the Latino saying 'don't drown in a glass of water' to become less hyperfocused; or the African-American term 'rebound' referring to making a comeback from a perceived failure (Hinton & Patel, 2017).

It is important to acknowledge that not all non-western people and culture has come to Canada and America through immigration. Indigenous nations within the western world have deep roots of rich cultural heritage that many identify with today (Stewart, 2008). Psychotherapy assumes a western understanding of mental health and the self, which can create a disconnect for any differing culture (Kirmayer, 2007). Indigenous peoples living in Canada seek mental health treatment disproportionately less, and the lack of cultural competency from western psychology may be to blame (Stewart, 2008). They are subject to unique distresses and traumas as a result of ongoing colonialism that has attempted to disconnect them from their cultures, which they rely on for wellness and healing (Stewart, 2008). Canada's mental health services do not adequately ground its paradigms in the Indigenous experience to properly serve these populations (Stewart, 2008). Psychotherapy carries the assumption of the individualistic self, championing self-efficacy, which does not always align with Indigenous ways of knowing and being (Kirmayer, 2007). Mental health from Indigenous perspectives often focuses on wellness and healing, which are both required when balancing the four parts of the self: spiritual, emotional, physical, and mental (Mussell et al., 1993; Stewart, 2008). Stewart interviewed mental health professionals who work with Indigenous clients and social services. Their knowledge described four connected meta-themes to model mental health: community, cultural identity, interdependence, and a holistic approach. Incorporating Indigenous knowledge and values into therapeutic interventions may increase positive expectancy in those communities, leading to

an increase in the usage of mental health services, and healing (Stewart, 2008).

Conclusion

Clinical psychology suffers from gaps in scientific knowledge and understanding on effectively treating culturally diverse populations. This is not the fault of clinicians who simply follow the guidelines in the DSM-5 and the evidence-based therapies they are trained in. These manuals provided by the APA need to embrace culture as a factor in all disorders and within the entire field of psychology, instead of creating a distinction between WEIRD disorders and cultural variations. The western system of mental health care systemically prioritizes the health of western culture and neglects the health of ethnically diverse cultures (Arnett, 2008; Bhugra, 1997; Lehti et al., 2009; Nielsen et al., 2017). Inevitably, the resulting society leaves cultural minorities with poorer mental health (Bhugra, 1997; Stewart, 2008). Marginalizing these groups results in a disproportionate increase in treatable mood disorders, propagating significant, preventable, consequences for their family, career, and other aspects of life, further perpetuating a detrimental cycle (Bhugra, 1997; Morgan et al., 2018). This is how the field of clinical psychology contributes to systemic racism through its western centric research, diagnostic manuals, and therapies.

Moving forward, including ethnically diverse participants in research is of paramount importance to address the roots of the problem. A proportionate amount of research and data representative of the diverse population would increase accessibility and lead to a greater emphasis on updating diagnostic manuals and developing effective psychotherapies. When conducting psychological research, the standard is to gather basic demographic information such as age and sex. Cultural identity should become a basic permanent demographic question so that variables can always be compared for potential differences. The current situation in research is dire with only 5% of the world being accounted for in 2008 (Arnett) and little to no improvement since then (Nielsen et al., 2017). Such a situation calls for potentially drastic measures, for example the APA could implement diversity requirements for participants in order to pass the peer reviewal process. There could be a participant diversity quota that universities must satisfy by the end of the year. Some could call this extreme, but the concern has been raised about whether psychology can even be considered a human science with such a small field of view (Arnett, 2008). The APA should also integrate research being published internationally to develop a more culturally comprehensive understanding of clinical psychology for the diverse populations living and immigrating to Canada and America.

Nonetheless, there are strategies to increase cultural competence in the clinician population. This can mean increasing personal awareness of how diverse cultures display symptoms of mental disorders and how that differs from the west. It can also involve putting in the effort to learn more about the different cultural groups who reside in their area of practice. Learning every culture is a difficult task, however the clinician's community may have a couple of prominent cultures which would be worth learning about to ameliorate therapeutic experience. In the absence of culturally diverse empirical data, clinical and personal experience is valuable and can be shared amongst colleagues, leading to increased cultural awareness, relevant training, and even research. Culture is the lens through which people develop, see, and interpret the world making it always relevant when therapeutically targeting cognitions, behaviours, and emotions. In the same way, the DSM and CBT are both a product of culture; western culture. As such, they must be removed from the context of their own bias before they can be properly related and applied to diverse clients. An increased sensitivity will result in more accurate diagnoses and efficacious psychotherapies.

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