Toward a Critically Conscious and Culturally Competent Telepractice in Psychology

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INTRODUCTION

As the field of psychology moves closer to implementing improved telehealth practices, it is also challenged by how it continues to make the same mistakes once made in traditional modes of care. An important question is how to remain critically conscious in the practice of psychology while using telehealth as a primary or secondary mode of mental health care delivery. Cultural competency continues to be an issue in traditional mental health practices, from the globalization of psychiatric standards to misdiagnosis within cultural frameworks. In the course of making such cultural considerations, understanding how the field can assess, treat, and implement the vast knowledge of Western psychology practices has been an area of increased development. Achieving a practice that features cultural competency extends far beyond considerations made in treatment, or assessments of language, sexual orientation, gender, tradition, religious/spiritual practices and beliefs, socioeconomic status, or geographical location. In the area of mental health care, there continue to be shortcomings in the global relationship dialogue of cultural competency.

This chapter provides an overview of the challenges inherent in traditional psychology practices, even as practitioners develop a foundation for critical consciousness. References are made to the literature outlining the many challenges and shortcomings made on cultural considerations within the practice of psychiatry, which are not to be mistaken with psychology. Additionally, this chapter explores established global mental health practices related to the use of telehealth, as well as guidelines for making cultural considerations when reaching out to remote or rural populations worldwide. A new standard for cultural competency will be explored within the context of telehealth practices; this will include an emphasis on how we currently understand cultural competency, and the impact it can have when used or not used. Suggestions for future research are made with an eye to furthering our understanding of psychological telepractice in rural communities and global mental health arenas.

BACKGROUND

Franz Fanon posed the notion of "a systemized negation of the other—to deny the other any attribute of humanity" in the social environment of the "colonial type" (Fanon, 1963, p. 182). Thus, describing the experience of the "other" in a tireless search for the meaning of their reality. Kitzinger and Wilkinson (1996) boldly describe Western social constructionism thus: "'We' use the other to define ourselves: 'we' understand ourselves in relation to what 'we' are not" (pp. 1-32). From the social constructionist

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perspective, there is skepticism of the "categories of knowledge," and there are assertions that the use of those categories leads to "viewing them as accounts shaped in accordance with cultural dictates" (Hare-Mustin & Marecek, 1994, pp. 531-537).

"The attribution of meaning is bound up with power" (Parker et al., 1995, p. 16), which means that "power relations" that are formed around groups subjected to inequality (e.g., gender, racial/ethnic) are influenced by the very definitions of "normal" that ultimately guide various psychological diagnoses. Landrine (1988) asserts that "what is constructed as 'normal' is limited to the experience of dominant cultural groups, and therefore precludes, and excludes, the experiences of women and people of color," for example (pp. 37-44); this assertion can also be applied to individuals from rural and/or indigenous communities. It is important to note, additionally, that this applies to those of "lesser" socioeconomic status more so than to the "creators of the norm" (pp. 37-44).

Social constructionists argue that the mental illness monologue that guides psychological theory and practice is molded by (a) definitions of "normal" that stem from a partial and elite perspective, and (b) stereotypical notions of gender, race/ethnicity, and sexuality (Hare-Mustin & Marecek, 1994). As such, there is an underlying theme in the DSM-IV Casebook of defining "normal" through constructions of race and gender. The Casebook contributes to a "gendered and raced" way of conceptualizing mental illness, and "explicit definitions of pathology" reflect in the use of "implicit definitions of normalcy" (Carmele, Daniels, & Anderson, 2001, pp. 229-247). Further, it is debated "whether the diagnostic categories in the DSM-IV reflect the existence of actual entities of mental disorders" or if they reflect a construct of mental illness based on theory and bias (Caplan, 1995, pp. 1-32). Although the field of Western culture sets a standard for accurate diagnoses that inform care, the very tool developed to be an efficacious resource has failed to make appropriate cultural considerations.

For example, in reviewing national databases from the United States and Britain, it becomes clear that whites are more likely to receive a diagnosis of an affective disorder than blacks, and the latter are more likely to be diagnosed with schizophrenia (Fernando, 1991). Additionally, blacks are more likely to be described as violent, dangerous, or angry, despite an identical symptom presentation between blacks and whites. Fernando (1991) argues that this differentiation allows for opportunities for racism to occur within the assessment and diagnostic process, as well as in treatment—and even that "racism in psychiatry is not an aberration" but the "normal condition" (p. 115). Fernando goes on to describe the very ways in which Western culture has perpetuated differences among individuals, given that the DSM-IV Casebook defines individuals as "white Americans," "non-white," and "non-American." As such, the Casebook once again draws a line of segregation between white Americans and the "other."

Furthermore, a review of the Casebook shows a discrepancy between the cases provided and racial/ethnic marking: of the 90 (55) adult male (female) case studies examined, 80% (87%) went unmarked for racial or ethnic references (Carmele, Daniels, & Anderson, 2001). The issue being presented relates to the need for differentiating between what the Casebook refers to as "non-white" or "non-American"—a need that has vast implications, aside from the most obvious of contributing to cultural construction while using the concept of "whiteness" as the normative point of reference (Carmele, Daniels, & Anderson, 2001).

Social and psychological knowledge that forms from historical and cultural frameworks should contribute to the context and process of scientific psychology, as they reflect societal norms (Moradio & Yoder, 2001). Carmele, Daniels, and Anderson (2001) demonstrate the lack of reference to a social constructionist framework within attempts to make cultural considerations, without being descriptive as to what various cultures are being considered. These readings shed light on the neglect of the field in addressing culture with respect to mental illness. Resources that aim to provide an educational atmosphere for students of psychology and psychiatry continue to fall short of developing and maintaining cultural competency in assessing and diagnosing mental illness across diverse populations.