Culturally Informed Child Psychiatric Practice

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As a result of the major demographic changes the United States is currently undergoing, there will no longer be a numeric majority of European-origin children and youth by 2030, and this is already the case among those 7 years old or younger.[1] Therefore, the patients treated by child and adolescent psychiatrists and child mental health professionals comprise an increasingly diverse group with unique and diverse needs. The acceptability of children's mental health services are highly influenced by attitudes, beliefs, and practices from their families' cultures of origin. The current science based around diagnosis and treatments, largely derived from research primarily with European-origin populations, has increasingly questionable validity for these emerging populations. At the same time, these new diverse populations face many different and at times increasing challenges regarding mental illness and emotional disturbances, including higher risks for certain forms of psychopathology, lower access to treatment services and evidence-based treatments, and higher burdens of morbidity and possibly mortality than Euro-Americans. For example, Latino and African American youth now have significantly higher rates of depression and suicidal

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ideation and attempts than Euro-Americans, as highlighted by the most recent Youth Risk Behavior Survey by the US Centers for Disease Control and Prevention.[2]

Cultural, ethnic, and racial factors relating to mental illness, emotional disturbances, and their treatment deserve closer attention and consideration. However, our health care system, including our mental health system, has not been effective in addressing the needs of culturally diverse populations, resulting in racial/ethnic disparities in health associated with higher morbidity and even mortality among minorities. This outcome has led to the increasing recognition of racial and ethnic disparities in mental health care (see the article by Alegria and colleagues elsewhere in this issue for further exploration of this topic). In this article, the authors outline the practical application of cultural competence principles in day-to-day clinical work by child and adolescent psychiatrists and other mental health professionals.

CULTURAL COMPETENCE MODEL

In response to these mounting clinical and service delivery challenges, cultural competence became one of the core principles of the children's community-based systems of care movement from its outset. Cross and colleagues[3] defined cultural competence within the context of serving children with serious emotional disturbances as a "set of congruent behaviors, attitudes, and policies found in a system, agency, or a group of professionals that enables them to work effectively in a context of cultural difference." These investigators identified a spectrum of cultural competence that has been demonstrated by societies and their institutions over centuries, ranging from cultural destructiveness (genocide, lynching, ethnic cleansing), cultural incapacity (segregation, discrimination, immigration quotas, services that break up families), cultural blindness ("equal" treatment for all, but not making distinctions in services offered on differences in values or beliefs), cultural pre-competency (realization of differences but insufficient provision of services), to cultural competence. Few societies have achieved the last stage, cultural proficiency (provision of innovative culturally specific services and research).

Cross and colleagues[3] went on to define characteristics that culturally competent clinicians and organizations represented. For clinicians, they cited the key elements awareness/acceptance of difference, awareness of own cultural values, understanding dynamics of difference in the clinical encounter, the development of clinically relevant cultural knowledge, and the ability to adapt practice to cultural context of the patient. For the organization, they cited valuing diversity, the performance of cultural self-assessments, management of the dynamics of difference, institutionalization of cultural knowledge, and the adaptation to cultural diversity (including policies, values, structure, and services), accounting for unique characteristics such as their socioeconomic level, level of acculturation, and experience with the service system. Cross and colleagues asserted that it was difficult for clinicians to practice in a culturally competent fashion without the support from a culturally competent organization.

CULTURAL CHALLENGES TO DIAGNOSIS AND TREATMENT

Diagnosing culturally diverse children can be challenging to unfamiliar clinicians. Children from diverse populations can demonstrate different symptomatology compared with Euro-Americans, with misdiagnosis being a significant challenge.[4,5] One cause of misdiagnosis is different symptom expression as compared with European-origin populations for common forms of psychopathology. For example, somatization and anger are symptoms more frequently associated with depression and anxiety in minority youth, leading to underdiagnosis.[6,7] African American and Hispanic children

who show anger or disruptive behaviors may have underlying internalizing disorders, but clinicians may focus on their externalizing symptoms.[8] Thresholds of distress are also different, as exemplified by differences in the degree of emotional reactivity seen during illness episodes. For example, depressed Asian-origin individuals show heightened reactivity during depression whereas Caucasians show less reactivity when depressed.[9] Similarly, Caribbean-origin Latinos can demonstrate more dramatic expressions of distress than Latinos originating from mainland Latin America and from European-origin populations.

Even normative affective expressiveness can vary greatly among and within cultural groups, and can similarly be misinterpreted as abnormal. For example, subdued expressiveness in Asian and American Indian children and adolescents, or aversion of eye contact with adults in Asian, African Americans, or mainland Latino children and adolescents, are signs of respect for elders. Native American culture emphasizes nonverbal communication, and feelings, particularly anger, are not to be expressed openly or verbally.

Diverse cultural groups' understanding of emotional distress and even mental illness can vary significantly, and can influence their expressions of distress and help-seeking behaviors. Idioms of distress are linguistic or somatic patterns of experiencing and expressing illness, affliction, or general stress. These idioms vary significantly among different ethnic/cultural groups; at times they may not even be indicators of psychopathology but of normal emotional distress, and as such can be misdiagnosed. For example, Latinos have specific cultural idioms of distress to describe the somatization process, such as *nervios* (nerves), anger-related illnesses such as *bilis* (bile) or *cólera* (rage), conditions associated with the hot-cold theory of disease such as *pasmo* (spasm of muscles), or afflictions attributed to the abnormal circulation of air in the body, such as *mal aire* (bad air) or *gases*. Some of these expressions take on unique symptom patterns or characteristics not found at all in the diagnostic nosology as outlined by the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition, Text Revised) (DSM-IV-TR),[10] and are referred to as culture-bound syndromes. For example, many Caribbean-origin Latinos describe a constellation of depressive, anxiety, somatic, and dissociative symptoms known as *nervios* (nerves) illness, and can experience an acute syndrome termed *ataques de nervios*, which combines these symptoms as well as agitation, dissociation, and even brief psychosis. These culturally specific idioms of distress or syndromes are based on explanatory models that are founded on or invoke spiritual, supernatural, or unique interpersonal beliefs, Such explanatory models and expressions may lead families to seek help from a spiritual healer rather than a mental health professional, thus making diagnosis and treatment more challenging.[11–14]

Diagnosing culturally diverse minority children is also more challenging due to the frequent presence of comorbidities. For example, stresses associated with immigration, acculturation stress, discrimination, and community violence contribute not only to depression but also to comorbidities of anxiety, disruptive behavior, substance abuse, and/or posttraumatic stress disorders.[15–17] As with many people of lower socioeconomic status, people of immigrant and minority backgrounds tend to postpone seeking treatment until either the child's situation is fairly critical, or the family is under significant distress from his or her symptoms. This situation may be related to their socioeconomic background, lack of insurance, multiple economic and social demands, stigma of mental illness, perceived barriers to treatment, and cultural values that are more present-focused and not as future- or prevention-oriented (see the article by Alegria and colleagues elsewhere in this issue for further exploration of this topic).

Biological factors related to culture have risen in importance as we have come to rely more on pharmacological treatments. Various genes control the metabolism of drugs through their effects on metabolizing enzymes, receptor regulation, and transporters, and their polymorphisms are associated with different racial and ethnic populations. The article by Lawson and colleagues elsewhere in this issue review the importance of ethnopharmacology in the mental health of culturally diverse children and youth. The rapidly growing knowledge from this field and its related field of pharmacogenomics will need to be rapidly incorporated into the knowledge base and treatment armamentarium of clinicians serving diverse populations.

Culturally Informed Clinical Assessment

Language and communication are critical in obtaining accurate clinical information and establishing a therapeutic alliance, especially with family members. However, many immigrants (particularly recent immigrant youth and especially parents) may have limited English proficiency and may not be able to fully participate in the clinical process. In those situations, translation and interpretation are critical to effective care, and interpreters should be readily available and have proper training in both translation and psychiatric terminology and services. These professionals should not only serve as linguistic interpreters but also as cultural consultants, helping to decipher verbal and nonverbal communication. The lack of interpreter services leads to the use of untrained translators, including family members, siblings, or even the affected child, without regard to the adverse impact of these practices. The use of the affected child should be always forbidden, given its demonstrated deleterious effects on family function.[18] Similarly, any rating instruments used should not only be translated to the language of the family member or child but should also (if possible) be validated and normed for that given ethnic/racial population.[19,20]

At times, diverse families may seek treatment under external pressure from social agencies, such as school, child welfare, or juvenile justice officials, or during an emergent situation as a result of postponement of services. Treatment thus tends to start on an adversarial and more urgent basis, with higher rates of involuntary commitment and premature termination from treatment.[4] These trends have significant implications for treatment effectiveness, as symptomatic improvement without remission because of premature termination is often associated with poor prognosis, more recurrences, and poorer outcomes. Stigma is also a major culturally related barrier to seeking mental health services. Many cultures have major negative associations with mental illness, while the fear of double discrimination (being culturally different as well as "crazy") also presents diverse families and youth from accessing services.[21] Some of these attitudes may originate historically in negative experiences with the mental health system by minority populations in the United States and by immigrants in their home nations.[22] The patient and family should be explicitly reassured about patient confidentiality to the fullest extent possible, because some immigrant families are very concerned about people in their community having knowledge about what is revealed.

Clinicians' self-awareness about their attitudes and perceptions of diverse patients is a critical aspect of effective cross-cultural evaluation and treatment. The report by the Institute of Medicine[23] titled *Unequal Treatment* has outlined how racial/ethnic disparities are related to subtle factors at the level of clinicians affecting their ability to objectively evaluate diverse populations in the face of cultural difference. The report hypothesizes 3 main factors contributing to health disparities: health systems-level factors—financing, structure of care, cultural and linguistic barriers; patient-level factors—patient preferences, refusal of treatment, poor adherence, and biological differences; and disparities arising from the clinical encounter. The investigators found

that the main clinician factors were related to clinicians' possible tendencies to engage in bias, uncertainty, and stereotyping when encountering diverse patients. No evidence suggests that providers are more likely than the general public to express racial/ethnic biases, but some evidence suggests that unconscious biases may exist. Uncertainty was found to be plausible, particularly when providers treat patients who are dissimilar in cultural or linguistic background and they are uncertain about how to approach their care. There is evidence that suggests that clinicians, like everyone else, use "cognitive shortcuts" that result from stereotyping.

Effectiveness in addressing cultural factors is related not only to knowledge about the family's cultural background but also to the clinician's ability to form a patient- and family-centered alliance in which he or she respect the family's knowledge and unique perspectives on the child, avoids stereotyping, and empowers them to make critical treatment decisions. Cooper and colleagues[24] demonstrated that the failure to form such alliances contributes to significant barriers in assessment and subsequent use of health services by minority patients, whereas race-concordant clinician-patient pairs tended to prevent such misalliance. The initial interview is a critical juncture to establish a strong therapeutic alliance. Factors such as the maintenance of appropriate distance, eye contact, use of appropriate gestures in greetings, and demonstrating genuine warmth can serve as grounds for establishing trust or developing mistrust of the clinician.[25]

It is also important to obtain critical contextual information during the initial evaluation about how culture influences the child's and family's understanding of the presenting problems and perceptions of needs. This interview includes asking about beliefs and attitudes about treatment, and inquiring after whether treatment was coerced in any way or whether there is conflict in the family around accessing services. The clinician should address these concerns as best possible, and empower the family and older child to make the most appropriate treatment choices available, addressing the perceptions of power differentials with the clinician. The clinician should inquire about barriers that may prevent the family from obtaining services for their child or adolescent, including bureaucratic barriers common in hospitals or clinics. Diverse children and their families are usually best served in community clinics located in familiar community locations where families feel comfortable, and should be affiliated with institutions that are favorably viewed by the community.[20]

The clinician should assess the strengths and needs of both the child or adolescent and of key family members, taking into account the danger of prematurely assigning diagnoses to the patient. The clinician should attend to variations in the expression of affect and behavior to prevent misdiagnosis, taking into account idioms of distress, differential expressions of normal emotions/affect and symptoms, and culture-bound syndromes.[13,14] The diagnosis and treatment of diverse children must be contextual, addressing psychosocial and cultural needs and being consonant within the values and beliefs of the minority family. The cultural and family context of symptomatology (eg, normative crises such as grief or mourning) must be considered in the assessment of a minority child. One must also assess the level of assimilation and acculturation of both the child and his or her parents and family, the presence of acculturation stress influencing symptoms, or whether cross-cultural dynamics may play a role in symptomatology (such as acculturative family distancing, discrimination, or marginalization from the majority culture or the youth's own culture).[26,27]

It is important to inquire about the family's cultural values, spiritual and religious beliefs and practices, family and gender roles, and language preference and fluency of key family members, the latter serving as a proxy for level of acculturation. The use of a cultural consultant, with the family's consent, can also be useful in dealing

with issues related to traditional beliefs and values, as well as their potential distortion (for example, whether spiritual preoccupations are consistent with the family's cultural or religious practices or are a psychotic distortion).[20] The inclusion of extended family members and nonblood relatives who possess an equivalent emotional bond (ie, "fictive kin"[28]) have been shown to be essential in obtaining the necessary collateral input needed for appropriate diagnosis and subsequent treatment recommendations.

A history of the immigrant child's and family's migration experience and possible traumatic experiences should be an essential part of the diagnostic interview. The history should include traumas before immigration (such as natural disasters, terrorism, warfare, or famine), during their journey (such as arduous journeys or victimization), or subsequent to arrival (such as prolonged and traumatic separations and reunifications from family members, social uprooting, and abrupt geographical relocations). For inner city children, it is important to inquire about exposure to violence at home or in their community, including the death of peers, sequential losses of parenting figures, and abuse or punitive childrearing.[20,29]

Models of Cultural Formulation

The DSM-IV-TR Outline for Cultural Formulation[30] provides a systematic method of considering and incorporating sociocultural issues into the clinical formulation. The Outline for Cultural Formulation is incorporated in the American Psychiatric Association Practice Guideline for the Psychiatric Evaluation for Adults. Although it may not be possible to do a complete cultural formulation based on the findings of the initial interview, these issues may be explored further during subsequent sessions with the patient and family. The information contained within the cultural formulation may be integrated with the other aspects of the clinical formulation or recorded separately. The cultural formulation includes the following 5 sections:

1. *Cultural identity* includes not only the individual's race/ethnicity, acculturation/biculturality, and language but also age, gender, gender identity, socioeconomic status, sexual orientation, religious and spiritual beliefs, disabilities, political orientation, and health literacy, among other factors.
2. *Cultural expressions and explanations of the illness* includes symptom expression and dysfunction, the patient's explanatory models of illness, and idioms of distress through which symptoms or needs may be communicated. Treatment history and preferences (including complementary and alternative medicine and indigenous approaches) are also identified. Due to possibly varying cultural identities and values of the child/adolescent and their parents due to acculturation, there may be varying cultural expressions and explanations of illness resulting in different treatment preferences.
3. *Cultural factors related to development, psychosocial environment, and level of functions* includes cultural factors related to psychosocial stressors, available social supports, and levels of function or disability, including the roles of family/kin and religion/spirituality in providing emotional and instrumental support. For children, one should also consider the impact of normal developmental expectations. All of these factors should be evaluated within the context of the youth's cultural reference group. As with the previous section, varying cultural identities may lead to value differences, which can cause intergenerational stress among family members.
4. *Cultural elements influencing the relationship between the individual and the clinician*. Differences in the cultural identities between the clinician and the child/adolescent and parents including race/ethnicity, language, and socioeconomic

status, among other factors, may add to the complexities of the clinical encounter. Transference and countertransference may be influenced by these cultural identity differences, interfering with or facilitating the treatment relationship. The impact of the clinician's sociocultural identity on the patient should be taken into account in the subsequent formulation of a diagnostic opinion. It is important for clinicians to know their limits of knowledge and skills rather than to reinforce damaging stereotypes and overgeneralizations.

5. *Overall cultural assessment* of the ways in which these cultural considerations will specifically apply to differential diagnosis and treatment planning.[30,31] As to differential diagnosis, the clinician must distinguish at the phenomenological level what is culturally congruent and what is psychopathological based on the information gathered in the previous sections. For example, hearing the voice of a deceased relative especially during bereavement may be culturally congruent for the cultural identity of the patient and family, and should not be misdiagnosed as an auditory hallucination. Second, the clinician must understand the possible misdiagnoses at the categorical level for a child or adolescent from a particular cultural background. For example, the DSM-IV-TR section on Specific Culture, Age, Gender Features for the diagnosis of schizophrenia notes that schizophrenia may be diagnosed more often in individuals who are African American and Asian American than in other racial groups.

Tseng[32] proposed the Cultural Analysis as a framework to understand patients' world views, with an emphasis on the importance of self and its relationships with others and with the world. The Cultural Analysis includes 3 broad domains: self, relations, and treatment. Within these domains basic elements are identified, with culture affecting the way in which each element is conceptualized, its relative importance, and its ideal or desired state. The *self domain* focuses on how the individual's overall self-concept is intrinsically tied to one's culture. Culture may affect the very building blocks of internal psychological experiences and observable actions, including affect, cognition, and behavior. Individual aims, goals, and motivating forces in life also depend on culture. Culture also influences the conceptualization of mind-body (dualistic vs more integrated), self-constructs, or theory of mind (individualistic or collectivistic); and the interpretation, antecedents, and acceptability (per cultural standards) of specific personal emotions. The *relations domain* addresses the cultural influence over the patients' world views regarding their relationships. This domain includes the patients' relationships with family and significant people in their life (hierarchical vs collateral vs exclusive nature of relationships); their relationship with nature and their environment (subservience, harmonious, or dominant); their relationship with and importance of material possessions; and their relationship with time orientation (the relative importance allocated to the past, present, or future) and how this affects such issues as spirituality and existential issues. The *treatment domain* highlights elements of therapy that may be especially influenced by culture. These elements include communication patterns, both verbal and nonverbal; problem-solution models (how patients conceptualize their difficulties); and the therapist-client relationship (including specified roles and transferences). Culture not only influences each element within the 3 domains individually but may also contribute to interactions within and across domains. In children and youth, the self domain will naturally be evolving developmentally and according to the youth's transition through the acculturation process. The relationship domain, which is very culturally value based, may be blended in its various orientation but will be abutting against what is usually a more traditional family interpretation. The therapist will most likely be bridging traditional and Western elements in the treatment

domain in the individual and family components of therapy and treatment, given the usual cultural differences across generations.

CULTURALLY INFORMED TREATMENT: GENERAL PRINCIPLES

Treatment of minority children must also be contextual and integrative, addressing psychosocial and cultural needs as well as psychological and biological ones. The clinician must evaluate and mobilize familial, neighborhood, and community resources, address contributing and sustaining environmental factors, and enhance strengths that the child and family bring to treatment. The clinician should support parents in the development of appropriate behavioral management skills consonant with their cultural values and beliefs. Parents must respect culturally established means of communication and family role functioning but also foster family flexibility in dealing with their bicultural offspring.[20] At the same time, the clinician should address internal acculturative conflict resulting from the clash between values/beliefs from the culture of origin versus mainstream culture.[17]

Psychological interventions should be congruent with the values and beliefs of culturally diverse children and their families. More traditionally acculturated children and families may be more accepting of and responsive to therapeutic approaches with a practical problem-focused, here-and-now orientation. Clinicians must be realistic about the acceptability of therapeutic interventions that may not be consonant with the family's cultural values. At the same time, clinicians must advise families about naturalistic parenting approaches that may be acceptable in their culture of origin but may be considered unacceptable or illegal in mainstream culture, such as the use of corporal punishment. Consultation from and collaboration with traditional healers (such as curanderos, santeros, shamans, and religious ministers or priests), including the use of rituals and ceremonies from the youth's culture, may be an important component of treatment of children from more traditional families. This component helps to prevent conflict between healing orientations that families may experience, and can help develop traditional healers as potential collaborators. Referral to same-culture clinicians or culturally specific programs (for example, community-based clinics oriented to specific cultural groups) has been associated with improved attendance and adherence.[20]

A value-neutral approach, whereby the clinician models openness to the diverse cultural influences on the child and judicious self-disclosure of similar experiences, is a helpful technique. Confidentiality in psychotherapy must be addressed so that the clinician is not perceived as "driving a wedge" between the child and his or her family, nor used by the patient to resist dealing with family issues. Home-based or community-based alternatives to hospitalization usually result in better outcomes for diverse children and youth, whereas involuntary hospitalization tends to recreate past traumas of oppression. If at all possible, out-of-home placement should be accomplished with the cooperation of the family and youth. An interagency system of care approach is consistent with cultural competence, because it uses community resources and empowers the child and family to a maximum extent.[20]

In addition to being mindful and addressing ethnopharmacological issues, there are numerous interpersonal aspects of pharmacotherapy with minority children that require attention. These aspects include proper informed consent and family collaboration, particularly with traditional cultural family decision-makers (typically outside of the nuclear family); demystification of medications (not only education on their mechanisms of action but also addressing suspicions and myths); and empowerment of children and families to make medication choices and address power differentials with clinicians.[20]

There are several evidence-based interventions that are gaining considerable research support for use with minority and immigrant children and youth. Kataoka and colleagues elsewhere in this issue outline the current state of the evidence around psychological and community-based interventions for culturally diverse populations. It behooves child mental health clinicians to use psychological interventions with evidence specific to the population of origin to which that the child or youth being treated belongs. In the absence of such evidence, it may be indicated to make adaptations to broadly evidence-based interventions that enhance their acceptability and applicability without altering essential elements.

There is little psychopharmacological research on minority and immigrant children. The Treatment of Adolescent Depression Study (TADS[33]) had a 26% minority representation among its participants, and minority status was found not to be significant moderator of acute outcome. However, no separate data analyses on the effectiveness of the treatments examined has been published. For attention-deficit hyperactivity disorder, atemoxetine appears to have equal efficacy for Latinos and African Americans in open-label trials,[34,35] while stimulants have demonstrated effectiveness, but there is some question as to whether behavioral interventions are needed in addition to reach equal effectiveness.[36] There are significant problems concerning minority inclusion in research trials, and one of the unfortunate results of such lack of evidence may be the significantly lower numbers of minority children and youth who receive pharmacotherapy.[37–39]

Culturally Informed Psychotherapy

There are several evidence-based psychotherapy interventions that are gaining considerable research support for use with minority and immigrant children and youth. Some research evidence exists on cognitive-behavioral and interpersonal psychotherapies with Latino and African American youth.[40,41] Some therapists have developed interventions that are specific for particular ethnic and racial groups, which have been evaluated for efficacy, such as storytelling through pictures,[42] the use of Magical Realism for traumatized Hispanic children,[43] and the use of classroom drama therapy for immigrant and refugee children.[44] Family therapy interventions have been used successfully to address at-risk minority and immigrant youth, and have focused on issues of acculturative family distancing, family-related separations, intrafamilial conflicts, and the effects of discrimination.[45,46] Group psychotherapy, particularly approaches that integrate cultural and ethnic identity themes, psychoeducation, and culturally consonant coping approaches, have been reported as both well accepted and successful.[47,48]

Psychodynamic psychotherapy, which had been discarded by many for lacking an empirical base, has been reevaluated through the rigorous lens of meta-analysis and effect size. Psychodynamic psychotherapy has been found to be as effective as cognitive-behavioral therapy (CBT) and pharmacotherapy for the treatment of depression and generalized anxiety.[49] In addition, recent empirical analysis of psychodynamic psychotherapy reveals that it also works by helping develop the person's inner capacities and strengths, and that the improvement continues after the therapy has ended. Rothe[29] has outlined a model for treating immigrant Hispanic adolescents and their families with psychodynamic therapy that has utility with other immigrant and minority groups. The model includes: (1) providing a holding environment and a safe place for the adolescent to express affects and experience containment and tolerance; (2) facilitating the mourning process associated with the losses of immigration, including the expression of sorrow, which may not be permitted by adult family members who may perceive it as the child's "ingratitude" for the parent's sacrifices;

(3) becoming an object of identification for the immigrant adolescent, so he can rehearse the newly acquired parts of his identity that belong to the new culture and delete the parts of his identity that are no longer useful in the receiving country; (4) allowing transferences to develop and analyzing them, using the therapy as a new, reconstructive emotional experience; (5) serving as a mediator of affects between the adolescent and his family, allowing for both to complete their process of adaptation to the new culture; and (6) serving as a mediator between the adolescent's family and the new culture, empowering the family, promoting their autonomy, and enabling them to create a new "American Milieu" in which to thrive.

In some cultures, psychotherapy is uncommon or stigmatizing. Testimonial therapy has proven to be successful with traumatized refugees whose culture has an oral tradition of storytelling. Narrating and reframing the story allows the person to translate pain into political and spiritual dignity and can serve to highlight resiliency factors, such as the courage and intelligence that it took to survive.[50] Rothe[51] has developed a psychotherapy model for treating child and adolescent refugees living inside refugee camps, to minimize psychological trauma and to prevent dissociative memories that result from these experiences.

Despite the recent progress in the development of culturally sensitive and evidence-based treatments, dropping out from psychotherapy among children and adolescents remains a significant problem, affecting 40% to 60% of the cases that receive outpatient treatment.[52] Of note, interpersonal psychotherapy was initially evaluated with a very large Hispanic sample[53] and was later shown to be more effective than CBT in a head-to-head trial,[54] lending support to the congruence between cultural values (*personalismo*, or interpersonal skills among Hispanics) and the effectiveness of psychotherapeutic interventions. Establishing a strong therapeutic alliance in the earliest points of contact with the family and the child and identifying factors that weigh on the burden of treatment continue to be important future challenges to clinicians who provide treatment to these culturally diverse populations.[29]

Cultural Transference and Countertransference

Cultural transference refers to a patient developing a certain relationship, feeling, or attitude toward the therapist because of the therapist's perceived cultural background; cultural countertransference implies the reverse phenomenon, namely, a therapist developing a certain relationship with the patient mainly because of the patient's perceived cultural background. Transference or countertransference is primarily based on the previous knowledge, impression, bias, or experience of a therapist or a patient, which has its own cultural influences in relation to a particular cultural group, but is also affected by the nature of the differences or similarities in the patient's and therapist's cultural background, race, gender, sexual orientation, socioeconomic background, and other identifying characteristics. Cultural transference or countertransference can be positive or negative, and can significantly influence the process of therapy, requiring timely attention and management. Cultural transference may express itself in various ways: mistrust, suspicion, and hostility; denial of therapist cultural differences; idealization and overcompliance; friendliness and overfamiliarity; or ambivalence toward the therapist. Countertransference can express itself as denial of patient's cultural differences, excessive curiosity about the patient's cultural background (often referred to as "cultural tourism"), or excessive feelings of anger, guilt, or ambivalence toward the patient.[32,55] It is important to remember that in work with children and youth, transference and countertransference principles apply to the therapeutic relationships with families, which in culturally diverse youth is perhaps more central to treatment than with mainstream culture youth.

CULTURAL CONSIDERATIONS IN CHILD SERVICES SETTINGS
School Settings

Schools are influential institutions for culturally diverse children and their families, given the frequent imperatives for achievement in school by families, and the child's exposure to peers as well as the mainstream culture primarily in that setting. However, they often face challenges in adapting to the increasing cultural/ethnic/racial diversity they face in the classroom, particularly around behavioral management. Weinstein and colleagues[56] proposed the model of culturally responsive classroom management (CRCM) to address the importance of culture in sociobehavioral management. Their conception of CRCM includes 5 essential components: (a) recognition of one's own ethnocentrism; (b) knowledge of students' cultural backgrounds; (c) understanding of the broader social, economic, and political context; (d) ability and willingness to use culturally appropriate management strategies; and (e) commitment to building caring classrooms. Another challenge faced by schools concerns bilingual education and teaching students with limited English proficiency. Elsewhere in this issue Toppleberg and Collins discuss the significance of language adaptation for culturally diverse students, including for their emotional and behavioral adjustment.

School-based services are generally well accepted and highly effective for diverse children. Cardemil and colleagues[57] demonstrated the effectiveness of a school-based cognitive intervention for depression as far out as 2 years. Kataoka and colleagues[58] demonstrated the effectiveness of school-based CBT for trauma-related depression or posttraumatic stress with Hispanic children and youth. Morsette and colleagues[59] have demonstrated effectiveness using CBT in schools with traumatized American Indian children and adolescents living on a reservation.

Child Welfare

The US Department of Health and Human Services[60] found that 22.5% of 3.5 million children who underwent an investigation for abuse or neglect were found to have been maltreated. The child welfare and juvenile justice systems are diverse culturally and ethnically. African American, American Indian, or Alaska Native children, as well as children of multiple races, had the highest rates of maltreatment (16.7, 14.2, and 14.0 per 1000 children, respectively). Hispanic and white children had lower rates (10.3 and 9.1 per 1000 children, respectively), and Asian children the lowest rate of 2.4 per 1,000 children of the same race or ethnicity. Black and Hispanic children are overrepresented in child welfare, with black children more likely to be referred and 3 times more likely than white children to be placed out of home, and Hispanic children more likely to be permanently placed out of home.[61,62] American Indian children had a historically high rate of referral to Caucasian foster homes and residential group homes and boarding schools, with the overt intent of protection from abusive families but with a hidden agenda of forced assimilation. The American Indian Child Welfare Act of 1978 was specifically passed to reverse such practices.[63]

Children in foster care are at high risk for having been abused, severely neglected, or neglected, and are at high risk for mental health problems.[64] Studies have shown that 50% to 80% of children in foster care suffer from mental health disorders.[65] Children in foster care have high use rates of mental health services,[66] and higher expenditures for mental health services and psychiatric drugs as well as for nonpsychiatric conditions than other low-income children.[65,67] However, McMillen and colleagues,[68] in a study of mental health services use by older youth in foster care, found that minority youth were less likely to receive outpatient therapy, psychotherapeutic medications, and inpatient services, and they were more likely to receive residential services.

There are many mental health issues to consider for children who are in sustained out-of-home placements, including the effects of multiple placements, changes of school, friends, family, and supports on a child's emotional state; the emotional and behavioral stressors that can result from a foster care system; and the emotional state of other children in the home as well as of the caregivers. For this reason, multiple sequential assessments are needed to evaluate changes in children's mental health as they adjust to new surroundings.[67] Older children, such as transition-age youth who are leaving child systems of care for the adult system, will need special services to ensure assistance in occupational, educational, and mental health needs.[69]

Clinicians should work through a culturally sensitive lens to be comprehensive. One particularly important issue is that of the racial/ethnic match between foster or adopted children and foster or adoptive families. Although many critics have asserted the "color blindness" of adoptions and the primacy of good intentions and affection, the importance of supporting the development of a strong ethnic/racial identity has been emphasized by researchers and policy-makers alike. The adoption of a child needs to be accompanied by the adoption of a child's culture of origin by the foster or adopted family, with that family having a responsibility for supporting the maintenance of meaningful connections between the child and his or her group of origin.[70] In the case of therapeutic foster care, foster parents from a similar racial/ethnic background can even serve as mentors and surrogate kin to the family of origin and facilitate family reunification. Kinship care has been a recommended method of foster care for minority families that strives to preserve the child's bond with his or her extended family.[71] In terms of clinical interventions, culturally diverse children in foster care have been reported to have a favorable response to a program combining wrap-around services with psychotherapy, trauma-focused CBT, and structured psychotherapy for adolescents, but have encountered difficulties with the implementation of such comprehensive interventions.[72]

Juvenile Justice

Juvenile justice involvement disproportionately involves minorities—the minority youth population in America is 34%, but more than 65% of the nation's detained youth are minorities.[73] African American youth are reported to engage in more aggressive behaviors compared with European American or Hispanic youth,[74] and are more likely to be referred to the juvenile justice system than the mental health treatment system, with Latino youth recently experiencing a similar pattern. Youth involved in the juvenile justice system have high levels of mental health needs. Incarcerated youth have been found to have similar prevalence rates of mental health disorders as hospitalized and community-treated youth in the mental health system. The majority of youth in the juvenile justice system meet criteria for at least one mental health disorder and also have high rates of comorbid mental disorders, with most having 3 or more mental health disorders.[75–77] There is a gender difference as well, with girls showing more internalizing disorders and being at higher risk (80%) than boys (67%) for having a mental health disorder.[78]

Referral to mental health services is variable, and is often based on sociodemographic variables: Caucasians, females, or African Americans[78] are more likely to be referred for mental health services. Rogers and colleagues[78] found that Latino youth specifically were under-referred, which may be due to cultural differences at an individual and systems level. Moreover, criminal history such as being a repeat[79] or violent offender[78] is related to referral, and the attitude or perception of need leads to referrals, because routine screening is often unavailable.

Child and adolescent psychiatrists have an important role in consultation with the juvenile justice system for evaluation, short-term treatment, and the development of aftercare plans for youth.[80] Effective programs are highly structured, intensive, use empirical treatments, use mental health professionals (not correctional staff) as treatment providers, collaborate, and deliver enough treatment.[81,82] Racial/ethnic representation among staff that reflects the population make-up of the youth allows for more positive identification and attachments by youth and more sensitive management and referral by staff.[78]

There are multiple therapeutic approaches that have been shown to be helpful in working with culturally diverse youth in the juvenile justice system. Multisystemic therapy is an intensive, multimodal, family-based treatment, with the goal of empowering families to cope with youth in the juvenile justice system, and to empower youth to cope with their surroundings. Wrap-around services integrate the child, family, school, and community to develop an individualized treatment plan.[82] Functional family therapy is a brief, family-centered approach for youth ages 11 to 18 and takes a culturally sensitive approach to motivate families.[83] Multidimensional treatment foster care (MTFC) is an alternative to residential treatment or incarceration for youths with severe delinquent behavior and emotional disturbance. Adolescents are placed into a structured living environment with local families who are trained and supervised.[71] Placing juveniles in adult prisons, youth curfew laws, and juvenile boot camps have been shown to be ineffective in decreasing recidivism or addressing the causes of youth crime.

Longitudinal studies looking at clinical factors that predict future involvement in the juvenile system is important. Further research on the influences of ethnicity as a risk indicator versus the confounded influence of poverty is needed, as well as identifying problems in the referral process that may overidentify minority youth in the juvenile justice system. The field also needs studies that look at how the referral source can influence a youth's access to mental health services. More broadly, long-term studies are needed to determine the factors regarding why some delinquent youths develop new psychopathology and others do not, protective factors, and how risk and resilience, along with vulnerable periods, differ by gender, race and ethnicity, and age.

CULTURALLY COMPETENT SYSTEMS OF CARE

As outlined by Cross and colleagues,[3] there are several main qualities to be demonstrated by culturally competent agencies or institutions: valuing and adapting to cultural diversity; ongoing organizational self-assessment; understanding and managing the dynamics of cultural difference; the institutionalization of cultural knowledge and skills through training, experience, and literature; and instituting service adaptations to better serve culturally diverse clients and their families.

Mental health services for minority and culturally diverse populations should be located in community settings where diverse populations feel comfortable accessing services. Services associated with institutions that are viewed favorably in the community, such as religious institutions, primary care settings, and nonmedical settings such as schools, are often less threatening and more easily accessed than a traditional mental health clinic. Tertiary medical centers are venues of last resort for diverse populations, being associated with death or involuntary long-term institutionalization. Reduced bureaucratic barriers and a personalized but respectful approach are important to facilitate access to services.[19]

Culturally competent practice can occur only within a system of care that has internalized and integrated cultural competence principles into every aspect of its

organization and functioning. This integration requires an operationalization of how cultural competence is applied within these systems. Further impetus has been provided by the advent of managed care. Diverse and minority children are widely covered under Medicaid, which is largely under state-sponsored managed care programs. Public managed behavioral health, combined with privatization, has adopted approaches that fail to address the multiple stressors faced by diverse children and families. It has also relocated many mental health services away from minority community settings, and selected against minority practitioners in provider panels due to their fewer "formal" credentials and serving "higher-risk" inner-city or rural clients. In recent years, however, there has been greater recognition of the value of community-based services for diverse and mainstream populations with multiple needs, though the quality and cultural orientation of such services varies greatly by state and community.

The response to these challenges has been to further operationalize the definition of culturally competent mental health services at both the provider and the systems level, which has led to the development of standards for culturally competent mental health services for mental health practitioners, provider organizations, health plans, and organized systems of care. Examples of such standards include the Center for Mental Health Services cultural competence standards.[19] These guidelines outline specific system standards (including governance, benefit design, quality assurance/improvement, information systems, and staff training and support) and clinical standards (access portals, triage and assessment, care planning, case management, treatment services, case management, and linguistic support). Moreover, they outline cultural competence planning processes for systems of care based on needs assessments of diverse populations being served involving the leadership and front-line providers.

SUMMARY

Work in the area of cultural competence in children's mental health continues to evolve and develop in parallel with other fields (such as education, health care, human services, and even business) as our society becomes aware of its importance to our multicultural society. The US Surgeon General's supplement on mental health, culture, race, and ethnicity[84] has further outlined significant issues in ethnic/racial mental health disparities and the need for expanding research in this important area. This report has complemented the Federal initiative on health disparities, which involves the identification inequalities not only in mental health status but also in physical health. Research in epidemiology and treatment outcome, and services research examining mental health disparities are pointing the way toward the best practices and reforms in system of care needed to improve the cultural competence of child mental health services.[20,84]

However, as Cross and colleagues[3] clearly asserted, the advancement of knowledge and skills needs to be matched with similar progress in attitudes in order for true progress to be made toward a culturally pluralistic and proficient system of care. It will be up to us as front-line practitioners in community systems of care to use the new knowledge about the influence of culture, race, and ethnicity in mental health but also to face the old ugly specters of prejudice and discrimination that still affect all of us.

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