

# Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

## INTRODUCTION

In recent years, there has been a tremendous growth in the cultural diversity of the United States. Discussion of cultural awareness, sensitivity and competence has occurred in many industries and organizations. There has been shift from a desire for societal “color-blindness” or “melting pot” idealism to the acceptance of multiculturalism. Healthcare organizations and healthcare providers, like other service-oriented organizations, have become sensitive to societal changes and the needs of service recipients. The goals now are not only to reduce racial or gender biases within the organization but also to understand and give better services to the culturally diverse U.S. populations.

Cultural competency education programs have been developed, but there has been no consensus on what information should be covered in specialty and subspecialty training. It is clear that attitudes, knowledge, and skills must be addressed. This includes teaching various cultural sensitivity and awareness approaches, learning specific information about categories of different cultural groups, as well as skills that are useful in approaching patients of different cultures. Models of cultural competency training have progressed from being primarily knowledge-based (i.e., learning facts about different cultural groups) to being grounded in an appreciation that it is impossible to know everything about the numerous groups. It is currently recognized that a foundation that fosters attitudes and skills is the paramount initial step to reduce health disparities.

As such, it is necessary for the child and adolescent psychiatrist to incorporate these concepts into training and practice. The time is now ripe to establish guidelines for training of culturally competent child and adolescent psychiatrists who can practice more effectively in the 21<sup>st</sup> century’s projected changes in U.S. demographics.

The environment in which we practice child and adolescent psychiatry is influenced by several factors:

1. **The expanding literature on healthcare disparities:** In 2001, *Unequal Treatment* was published by the Institute of Medicine (IOM). Commissioned by the U.S. Congress, this study reviewed the literature disparities in healthcare, concluding that medical treatment is often influenced negatively by the race and ethnicity of the patient. Healthcare disparities are “differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.” This report has generated a great deal of research and new knowledge. Some of the 21 IOM findings and recommendations follow:

### **Findings:**

- Racial and ethnic disparities in healthcare exist, and, because they are associated with worse outcomes in many cases, are unacceptable.

## Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

- Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality and evidence of persistent racial and ethnic discrimination in many sectors of American life.
- Many sources – including health systems, healthcare providers, patients, and utilization managers – may contribute to racial and ethnic disparities in healthcare.
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare....a greater understanding of the prevalence and influence of these processes is needed and should be sought through research.

### Recommendations:

- Increase awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders.
  - Increase healthcare providers' awareness of disparities.
  - Promote the consistency and equity of care through the use of evidence-based guidelines.
  - Support the use of interpretation services where community need exists.
  - Implement multidisciplinary treatment and preventive care teams.
  - Integrate cross-cultural education into the training of all current and future health professionals.
2. **Shifting population demographics:** By the year 2042, it is anticipated that Americans of European origin will no longer be the majority. By 2050, 54% of the population is expected to be a member of a racial or ethnic minority (U.S. Census Bureau <http://www.census.gov/Press-release/www/releases/archives/population/012496.html>). For children, over half will be members of "minority" groups by 2023. In 2008, 44% of children were members of minority groups, and it is expected that 62% will be so in 2050. Approximately 30% of U.S. residents will be Hispanic/Latino by 2050, with African-Americans comprising 13% and Asian-Americans 7.84%. <http://www.census.gov/population/www/projections/tablesandcharts.html>

The rate of growth of the "minority" populations is highest in areas that have not previously been considered diverse, including the South and Midwest (Pumariega, Rogers & Roth, 2005). The numbers of immigrant and refugee residents of the U.S. is also growing. In 1970, the foreign-born population of the United States was 4.7%. In 2000, that reached 10.4%, and 12% in 2004. The United Nations High Commissioner for Refugees (UNHCR) estimates that out of an estimated 15.2 million refugees worldwide, 279,548 live in the U.S. In addition, the immigration from Europe and Canada has declined while that from non-European minority groups has grown dramatically (Pumariega, Rothe & Pumariega). In addition to being members of minority groups,

## Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

immigrants and refugees often face/have survived the additional stressors of exposure to the traumas of war, torture, or natural disasters, the process of immigration, and changes in family structure necessitated by these events. Children, as well as adults in these families, may have lost close family members and friends, and find themselves with less psychosocial supports (Pumariega, Rothe & Pumariega). The acculturation process can have significant impact on both children and adults in these families.

		2000	2025	2050
One race	White	75.1%	77.29%	73.98%
	Black or African American	12.3%	13.04%	12.97%
	Asian	3.6%	5.91%	7.84%
	American Indian and Alaska Native	0.9%	1.13%	1.24%
	Native Hawaiian and other Pacific Islander	0.1%	0.23%	0.28%
	Some other race	5.5%		
Two or more races		2.4%	2.41%	3.69%
Hispanic or Latino		12.5%	21.20%	30.25%
White, not Hispanic		69.1%	57.82%	46.32%

2008 estimates from the U.S. Census Bureau found that 47% of U.S. children under the age of 5 were members of minority groups and that 25% of them were Hispanic. For all children under 18, 44% were a minority and 22% were Hispanic.

3. **Requirement by the ACGME:** The requirements for residency training in both general psychiatry and child/adolescent psychiatry include the provision of “didactic instructions about American culture” and “supervised clinical experiences with patients of a variety of ethnic, racial, social and economic backgrounds.” Similar requirements exist for medical students (Lu and Primm, 2006).
  
4. **Mandate by federal, state and other funding agencies and by the managed care organizations:** Most regulatory governmental and non-governmental agencies now require mental health agencies to provide special considerations in assessment and treatment of minority populations. Child advocacy groups at the national, state and local levels have reinforced this consideration of cultural responsiveness in public and private programs. Those providing care to children and families in all systems of care must be prepared to understand and embrace as nonpathological the differences in child-rearing, expected roles, patterns of communication, acceptable behaviors, and coping mechanisms found in the wide variety of cultures now present in the United States (Pumariega, Rogers & Rothe).

## Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

5. **Inclusion of cultural considerations in the DSM-IV:** In 1994, the Diagnostic and Statistical Manual of Mental Disorders, for the first time, described three types of culturally relevant information in the diagnostic assessment:
- cultural variations in the clinical presentations of major psychiatric disorders,
  - culture-bound syndromes, and
  - an outline for a cultural formulation, which has not yet been included as part of the multi-axial diagnosis.

The established diagnostic procedures now require clinicians' consideration of the cultural dimensions of clinical work.

6. **The diverse demographic backgrounds of residents:** About one-third of child and adolescent psychiatric residents and about 40% of general psychiatric residents in the 1995-1996 academic year were from ethnic minorities. The increasing enrollment of ethnic minorities in U.S. medical schools, and the increasing number of international medical graduates in general psychiatric residencies will result in a higher availability of child and adolescent psychiatric residents of ethnic minority backgrounds. The number of female medical students and female psychiatric residents from a multiplicity of cultural backgrounds has also been growing steadily.

About 44% of psychiatry residents in the 2007-2008 academic year identified themselves as African American (7.4%), Latino/Hispanic (6.9%), Asian (24.2%), American Indian or Alaska Native (0.2%), Native Hawaiian/Other Pacific Islander (0.5%) or other (13.2%). The self-descriptions of 13.2% are unknown, with 49.8% identifying themselves as White. These are consistent with numbers for the previous two academic years (APA, 2008). Thirty-three percent of residents were born outside the U.S. and 8.72% were non U.S. citizens. Thirty percent of psychiatry residents were international medical graduates. Of child and adolescent psychiatry fellows, 8.7% were African American, 1.7% American Indian or Alaska Native (AI/AN or NH/PI), and 23.8% were Asian and 11% were Latino/Hispanic (AAMC, 2008).

Source	Program	White	African-American	Asian	AI/AN or NH/PI	Other/unknown	Latino
AAMC	Psychiatry	58.3%	8.3	26.9	1.0	5.5	12.3
AAMC	Child/Adolescent	57.4	8.7	23.8	1.7	8.4	11.1
APA	Psychiatry	49.8	7.4	24.2	0.7	4.8/13.2	6.9

7. **Influence of culture on child development:** From infancy to senescence, culture is a major factor in the developing personality through different child rearing practices and varied influences of the cultural milieu. Conceptualizations of normal and abnormal behaviors, and especially their treatment, are strongly related to cultural beliefs and

## **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

practices. Examples are issues relevant to family rituals, the disciplining of children and social and religious milestones. The growth, development and parenting of children are fraught with cultural influences. A failure to recognize this results in misguidance and misdiagnosis by child mental health professionals (Pumariega, Rothe, and Rogers 2009).

### **DEFINING CULTURAL COMPETENCE**

Culture has long been recognized as particularly significant in understanding human development, clinical assessment and treatment of mental disorders (Opler & Singer, 1956; Yamamoto, James & Polley, 1968; Giordano, 1973; Papajohn & Spiegel, 1975). In 1969, the American Psychiatric Association (APA) recognized transcultural or cross-cultural psychiatry as a specialized area of study. The need for training in cultural diversity has been addressed by individual practitioners (Pinderhughes and Pinderhughes, 1982; Bradshaw, 1978) and such training has been proposed by a number of professional groups, including the American Academy of Child and Adolescent Psychiatry. Four committees of the APA have published curricula (Thompson, 1995; Stein, 1994; Spielvogel, Dickstein, and Robinson, 1995; Garza-Trevino, Ruiz P, Varegos-Samuel, 1997) that pertain to four different cultural/racial groups: 1) American Indian, Alaska Native, Hawaiian, 2) Hispanic, 3) gay and lesbian, and 4) women.

Comas-Diaz (1988) recommended that the American Psychological Association, in 1985, “reorganize its temporary Task Force on Minority Education and Training into a permanent Committee on Ethnic Minority Human Resources Development... this committee advocates training in cultural diversity as a prerequisite to providing psychological services to ethnic minority populations” (pp. 354-355).

The matter of cultural competence in the clinical care of children and adolescents has received wide attention (Cross, Bazron, Dennis & Issacs, 1989). Cross, et al. (1989) defined cultural competence as “a set of congruent attitudes, behaviors and policies that are part of an agency, system or a professional group and that enables these groups to work effectively in cross-cultural situations.” To achieve this goal, an individual practitioner must accept differences and beware of judging them as deviant, be aware of one’s own culture, understand the dynamics of working cross culturally, develop cultural knowledge, and adapt practice skills to fit the patient’s cultural context.

Some features of cultural competence had been addressed previously by child and adolescent clinicians. Chess, Clark and Thomas (1953) addressed the importance of a cultural evaluation in psychiatric assessment and treatment, and Loeff (1979) addressed the need for the clinician to examine the impact of various cultural factors on child development. Although his focus was on families in Appalachia, his message has wide applications.

Waldron and McDermott (1979) called attention to the cultural influences on approaches to the treatment of illness. “No cross-cultural treatment of children or adolescents should be

## **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

attempted without awareness of and respect for the risks, problems, and areas of difficulty involved. A simple transfer of the techniques developed in one culture to application in another cannot be effective” (p. 443). In 1970, Adams discussed the impact of racism on biracial (black patient/white therapist) dyads and made suggestions for several measures that should help minimize the white therapist’s racial distortions and ensure successful psychotherapeutic interventions. Spurlock (1985) in a paper titled “Assessment and Therapeutic Intervention of Black Children” underscored the need for competent clinicians to be alert to cultural differences and diversities within the racial group.

Cultural competence has been addressed, directly or indirectly, by child and adolescent mental health practitioners in their daily work and in their publications. The following publications are illustrative of this thrust: Vargas and Berlin (1993) noted that “the challenges of being culturally responsive must be confronted before children come to the hospital and must entail more than verbal efforts.” Canino and Spurlock (1994) offered clinical guidelines for mental health service providers who work with economically disadvantaged children and adolescents from culturally diverse backgrounds. The authors’ primary objective was to offer concrete suggestions about how to elicit relevant history information and whom to select as the informant. This included recommendations regarding how to use available diagnostic criteria, and how to intervene, with whom, and with which treatment strategies.

Cultural competence defines a set of knowledge-based and interpersonal skills that enable an individual to understand and work effectively with individuals of diverse cultures (including one’s own) across all categories of socioeconomic status, gender, religious, racial, and ethnic background. The shared values, norms, customs, history, art, language, etc., in a group of people represent their culture. Specific skills to be acquired by a culturally competent child and adolescent psychiatrist include the abilities to:

- interview effectively and communicate with children and families of different cultural backgrounds – recognizing that the spectrum of cultures is always changing. This may require the effective use of interpreters for non-English speaking immigrants.
- formulate a diagnosis that includes the cultural dimensions relevant to clinical issues and psychopathology. So-called culture-based syndromes may be considered.
- formulate treatment plans that are culturally sensitive to the child’s and the family’s concept of mental illness and perceived severity of illness.
- provide an effective psychotherapeutic and psycho-pharmacotherapeutic intervention specific to the cultural background of the child and the family, with an understanding of possible differences in treatment expectations and outcome.
- advocate the accessibility for all patients to mental health services and other supportive resources, such as to primary care, education, financial assistance,

## **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

juvenile justice, child welfare and natural helpers. The ability to advocate the delivery and quality of care for underserved populations is imperative.

- advocate within managed care systems that a culturally diverse mix of enrollees and physicians be adopted in order to improve treatment effectiveness.
- appreciate that a response to treatment may be a function of cross-cultural dynamics, and often a product of the interaction of a clinician and family who are from two different cultures.
- discuss the impact of cultural concerns on medical ethics and on the definition of health and illness.

### **CONCLUSION**

Failure to attain cultural competence during the child and adolescent psychiatric residency will result in a limited understanding of personal cultural biases, misdiagnoses, and ineffective treatment of people of diverse cultural backgrounds. A service system that is not responsive to the needs of culturally diverse populations may become subject to closer scrutiny by the local communities and its elected officials.

# Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

## CURRICULUM

We have delineated three goals to be covered by the end of child and adolescent psychiatry training. These goals can be integrated into currently existing topics and do not have to be separated into a separate course. It is recognized that for some trainees, initial cultural competency training may have begun during medical school and/or general psychiatry training. A needs assessment is an appropriate way to ensure what topics most require coverage for each cohort of trainees. For each goal we have defined basic, intermediate and advanced level competencies. These competencies have been crosswalked with the Accreditation Council for Graduate Medical Education (ACGME) competencies in order to help illustrate how cultural competency impacts the functioning of a child and adolescent psychiatrist. Suggested methods for teaching each goal and a reference list are also provided.

### GOALS

**Goal 1:** Understand the concept of cultural competence and its application in the practice of child and adolescent psychiatry: knowledge, skills, and attitudes.

**Goal 2:** Knowledge of normal development compared to pathology within the concept of cultural identity.

**Goal 3:** Understand the cultural competence model of service delivery and systems based care, including the development of skills and the necessary attitudes and perspective to work in or consult to a system that provides care for children from culturally diverse populations and their families.

### LEVELS OF COMPETENCY

**Basic:** The minimum level of cultural competency that a fellow should have upon completion of child and adolescent psychiatry training.

**Intermediate:** The recommended level of cultural competency for a practitioner who is working in a community with a diverse patient population.

**Advanced:** The level of cultural proficiency to which a practitioner can aspire as a result of experience and scholarship.

### ACGME Competencies Legend:

**CS:** Clinical Science

**COMM:** Interpersonal Skills and Communication

**PC:** Patient Care

**PBL:** Practice Based Learning and Improvement

**PROF:** Professionalism and Ethical Behavior

**SBP:** Systems-Based Practice

# Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

## GOAL 1

**To understand the concept of cultural competence and its application in the practice of child and adolescent psychiatry.**

Objectives: At the end of the course/training residents will be able to:

### Knowledge

Objective	Level of Competency	ACGME Competencies
Define cultural competence.	Basic	CS, PBL
Recognize culture as a broad concept that goes beyond the focus on the study of racial/ethnic identities and includes sub cultures of religion, economic strata, Western/mainstream medicine, patient role, intergenerational conflict, etc.	Basic	CS, PC
Define physician role in culturally competent patient care.	Basic	CS, PC, PBL
Recognize disparities in mental healthcare.	Basic	CS
Describe differential risk factors, diagnostic patterns, and symptom expression in different ethnic groups, including culture-bound syndromes.	Basic	CS
Learn about specific characteristics of normality and distress in ethnic groups in the community where the clinician serves.	Basic	PBL

### Skills

Objective	Level of Competency	ACGME Competencies
Respectfully and effectively communicate healthcare information with diverse patient populations.	Intermediate	PC, COMM, PROF
Assess a patient using a cultural formulation.	Intermediate	CS, PC, PBL
Conduct a culturally sensitive and appropriate psychiatric interview with the patient and family taking into account the unique cultural variables of both, not limited to ethnicity.	Intermediate	PC, COMM
Conduct a mental status exam from a culturally-informed perspective.	Intermediate	CS, PC, COMM
Formulate a diagnosis that includes the cultural dimensions relevant to clinical issues and psychopathology.	Intermediate	CS, PC
Give attention to physical appearance, affect, behaviors and behavioral norms, language and self-image as being culturally determined.	Intermediate	CS, PC, PBL

## Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

Use the cultural formulation in negotiating an effective psychotherapeutic and psychopharmacotherapeutic intervention with an understanding of possible differences in treatment expectations and outcome.	Intermediate	PC, COMM
Acquire proficiency in ongoing communication across cultural differences between clinician and patient-family.	Intermediate	PC, COMM

### Attitudes

Objective	Level of Competency	ACGME Competencies
Value diversity and all cultural orientations as valid except when they violate basic human rights.	Intermediate/Advanced	PROF
Appreciate the need for cultural competency in clinical encounters.	Intermediate/Advanced	PC, PROF
Develop a therapeutic relationship with a culturally different patient.	Intermediate/Advanced	PC, COMM
Be comfortable with interface of his/her own personal values and socio-cultural background and cross-cultural patient care.	Intermediate/Advanced	PC, PROF
Be aware of patient's and family's prejudices and biases, and show they may affect clinical judgment.	Intermediate/Advanced	CS, PC, PROF
Effectively keep own internal biases in check to establish an objective, patient and family-centered therapeutic perspective.	Intermediate/Advanced	PC, COMM, PROF

### Methods

Following are suggested methods for teaching Goal 1 objectives:

Objective	Content	Methods
Knowledge	<ul style="list-style-type: none"> <li>Cultural competency – definition and concept</li> <li>LEARN/CLEFS/CRASH models</li> <li>Articulate ways in which cultural differences including the culture of medicine, poverty, religion, etc. have an impact on patient care</li> <li>Review of culture-specific psychiatric epidemiology and culture-bound syndromes of local racial/ethnic groups</li> <li>Appreciate disparities in access and delivery of mental healthcare: Surgeon General's Report,</li> </ul>	<ul style="list-style-type: none"> <li>Didactic sessions, include residents as teachers</li> <li>Readings (see bibliography), highlight evidence-based practices</li> <li>Lectures by representatives of diverse communities in the program's vicinity</li> <li>Use diversity of program trainees to educate</li> </ul>

## Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

	<ul style="list-style-type: none"> <li>etc.</li> <li>• Knowledge about idioms of distress, differential symptomatology, behavioral norms, help-seeking behaviors, and explanatory models of mental illness for main cultures in community.</li> </ul>	<ul style="list-style-type: none"> <li>• Film nights, include residents in planning, as discussion leaders, coordinating</li> <li>• Cultural field trips to restaurants/museums/festivals</li> <li>• Evaluation tool</li> </ul>
Skills	<ul style="list-style-type: none"> <li>• Conduct a patient centered interview</li> <li>• Assessment of patient using cultural formulation</li> <li>• Cultural elements of mental status exam</li> <li>• Focus attention on attire, affect, language and self image as determinants of patient and clinician culture</li> <li>• Effective use of interpreters</li> <li>• Exercise reflective practice around social and cultural issues</li> </ul>	<ul style="list-style-type: none"> <li>• DSM-IV cultural formulation</li> <li>• Observed patient interview</li> <li>• Culturally-informed patient write-up</li> <li>• Supervision by 'expert' faculty</li> <li>• Modeling of reflective practice by 'expert' faculty</li> <li>• DVD: Culture of Emotions</li> <li>• Small group exercises and role play</li> <li>• Journaling</li> <li>• Clinical practice</li> <li>• Evaluation tool</li> </ul>
Attitudes	<ul style="list-style-type: none"> <li>• Appreciate need for cultural competency skills in medical practice</li> <li>• Establish a therapeutic relationship with a culturally diverse patient to the clinician.</li> <li>• Exercise cultural sensitivity in all aspects of patient related care</li> </ul>	<ul style="list-style-type: none"> <li>• Experiential group</li> <li>• Group role play focusing on assumptions about patients and those that patients have</li> <li>• Self-reflection journal</li> <li>• Clinical practice supervision</li> <li>• Film nights, include residents in planning, discussion leaders, coordinating</li> <li>• Cultural field trips to restaurants/museums/festivals</li> <li>• Evaluation tool</li> </ul>

# Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

## GOAL 2

**Knowledge of normal development compared to pathology within the concept of cultural identity.**

Objectives: At the end of the course/training residents will be able to:

### Knowledge

Objective	Level of Competency	ACGME Competencies
Describe normal developmental differences and developmental expectations among diverse populations and how these influence normal behavior.	Basic	CS, PC, PBL
Describe the roles that cultural values and cultural explanatory models of mental illness play in illness expression and help-seeking behaviors.	Basic	CS, PC, PBL
Articulate factors that contribute to misassessment and misdiagnosis of normative and dysfunctional behaviors in evaluating diverse children and youth.	Basic	CS, COMM, PC, PBL, PROF, SBP
Describe differences in definition of roles, boundaries, and function of families across different cultures.	Basic	CS, PBL
Describe differences in child-rearing practices across different cultures.	Basic/Intermediate	CS, PBL
Articulate the importance of culture in the process of normal identity formation.	Basic	CS, COMM, PC
Describe the impact of spirituality in the process of development.	Basic/Intermediate	CS, PBL

### Skills

Objective	Level of Competency	ACGME Competencies
Reflect on his/her own cultural background/identity.	Basic/Intermediate	PROF
Recognize transference and countertransference reactions related to cultural identity.	Intermediate/Advanced	PROF
Use the knowledge of cultural explanatory models of mental illness and the roles that these play in illness expression and help-seeking behaviors in everyday patient interactions.	Intermediate/Advanced	CS, PC, SBP

## Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

Distinguish normal variants versus dysfunctional behaviors within a cultural context.	Intermediate/Advanced	PC, PBL
Effectively help diverse families recognize and address parenting practices that are not legally acceptable in mainstream American society.	Intermediate/Advanced	PC, SBP
Assist diverse families in navigating the acculturation of their children and avoiding inter-generational cultural conflict.	Intermediate/Advanced	CS, COMM, PC, SBP

### Attitudes

Objective	Level of Competency	ACGME Competencies
Recognize physician biases around normal development, family organization, and child-rearing practices and keep them in check so they do not influence clinical judgment.	Basic	CS, PBL, PROF
Develop a sensitivity to the common cultural norms of various ethnic groups.	Intermediate	PBL, SBP
Develop an acceptance of variants in development, family organization, and child-rearing while maintaining value neutrality.	Basic/Intermediate	CS, COMM, PC, PBL, PROF, SBP
Appreciate the challenges of bicultural identity formation.	Intermediate/Advanced	CS, COMM, PC, PBL, SBP
Appreciate the adverse impact of discrimination and marginalization on identity development.	Advanced	CS, COMM, PC, PBL, PROF, SBP

### Methods

Following are suggested methods for teaching Goal 2 objectives:

Objective	Content	Methods
Knowledge	<ul style="list-style-type: none"> <li>• Cultural identity – definition and stage</li> <li>• Helms and Cross models ; include Helms’ white American identity development</li> <li>• Review of specific differences in development of local racial/ethnic groups</li> <li>• understand the concept of “privilege” for those in majority groups</li> <li>• understand the concept of “biculturality” for those in all groups</li> </ul>	<ul style="list-style-type: none"> <li>• Didactic sessions</li> <li>• Readings (see bibliography)</li> <li>• DSM-IV TR Cultural formulation</li> <li>• Lectures by community representatives</li> <li>• Observation of children from diverse cultures in normal developmental settings in their own communities</li> <li>• DVD: Real Women Have Curves</li> <li>• DVD: Bend it like Beckham</li> </ul>

## Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

	<ul style="list-style-type: none"> <li>• understand the potential cultural effects of cross-racial foster care and adoption</li> <li>• understand the effects of immigration on cultural identity development, particularly the impact on younger, more acculturated family members who may be used as cultural and linguistic interpreters.</li> <li>• understand the development of faith and spirituality in children and how this is exhibited in families</li> <li>• understand the development of gay/lesbian identity development</li> <li>• understand the development of feminine identity development</li> <li>• understand how cultural stereotypes are developed and how culture is perceived in children</li> </ul>	<ul style="list-style-type: none"> <li>• DVD: My Son the Fanatic</li> <li>• Develop your own screening culture questions for your intake interview. How will you know when you need to follow up and ask more questions?</li> <li>• PBL case</li> </ul>
Skills	<ul style="list-style-type: none"> <li>• Identify aspects of own cultural background that might conflict with that of patients</li> <li>• identify own stage of cultural identity</li> <li>• identify transference and countertransference reactions related to cultural identity</li> <li>• identify potential differences in the mental status exam that are related to cultural development</li> <li>• assess the importance of faith to a child and family</li> </ul>	<ul style="list-style-type: none"> <li>• Experiential group</li> <li>• <a href="http://implicit.harvard.edu">implicit.harvard.edu</a></li> <li>• Small group exercises - (discuss stereotypes of own and other groups)</li> <li>• journaling</li> <li>• clinical practice</li> <li>• Faculty observe interviews with patients for recognition of cultural concerns.</li> </ul>
Attitudes	<ul style="list-style-type: none"> <li>• identify own level of knowledge of local cultural groups</li> <li>• identify own attitudes regarding local cultural groups</li> <li>• identify means to effect change in systems in regards to cultural identity</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural competence health practitioner assessment</li> </ul>

# Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

## GOAL 3

**Understand the cultural competence model of service delivery and systems based care. This includes the development of skills and the necessary attitudes and perspective to work in or consult to a system that provides care for children from culturally diverse populations and their families.**

Objectives: At the end of the course, the resident will be able to

### Knowledge

Objective	Level of Competency	ACGME Competencies
Name existing community resources available for the various ethnic groups of patients.	Basic	PC, SBP
Name the different faith healers that different ethnic groups in their community commonly use in adjunction to other treatment or solely as help-seeking behaviors.	Basic	CS, SBP
Name the various psychosocial agencies existing within their communities.	Basic	SBP
Be aware of the local social world of the patient and family and its influence on help-seeking behavior, illness manifestation and treatment.	Basic	COMM, SBP
Define the basic elements of a culturally competent system of care.	Basic	CS, SBP

### Skills

Objective	Level of Competency	ACGME Competencies
Effectively use interpreters for non-English speaking patients.	Basic	COMM, PC, SBP
Incorporate the local social world of the patient and family in the treatment plan.	Intermediate	PC, SBP
Address influence of spirituality or lack thereof in the patient and family's understanding and management of illness.	Intermediate	COMM, PC, CS
Integrate the spiritual world of patient and family in the treatment plan.	Intermediate	PC, SBP
Discuss evidence-based practices with diverse populations.	Advanced	CS, PC
Advocate for accessibility and delivery of quality	Advanced	SBP

## Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

care to mental health services and other supportive resources, such as primary care, education, financial assistance, juvenile justice, child welfare and natural helpers for all patients.		
Discuss mental health disparities across different ethnic/racial populations, and identify factors that contribute to their development and sustainment.	Intermediate	CS, SBP
Use natural cultural and community strengths/resources within a systems of care model.	Intermediate	PC, SBP
Ability to pursue a culturally-competent informed consent and psychoeducational process for both pharmacotherapy and psychological/psychosocial services involving families and youth.	Advanced	COMM, PC, SBP

### Attitudes:

Objective	Level of Competency	ACGME Competencies
Display a willingness to negotiate treatment to incorporate cultural variables and the patient's local world.	Basic	COMM, PROF
Utilize a "team" approach to care incorporating the family's beliefs about illness and treatment as well as other modalities of treatment sacred to the patient (within clinical judgment).	Basic	COMM, PROF, SBP
Adopt a value neutral approach around traditional versus non-traditional treatment selection by the family within the system of care.	Basic	PROF, SBP

### Methods

Following are suggested methods for teaching Goal 3 objectives:

Objective	Content	Methods
Knowledge	<ul style="list-style-type: none"> <li>Existing community resources, as well as natural and cultural community strengths</li> <li>Psychosocial agencies available and cultural determinants of their use</li> <li>Acculturation conflicts within families and determination of use of systems given that variable</li> </ul> Mental health disparities across different	<ul style="list-style-type: none"> <li>Didactic sessions</li> <li>Readings including latest literature on cultural competency evidence-based practices (see bibliography)</li> <li>Lectures by community representatives</li> <li>Observation of children from</li> </ul>

## Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training

	<p>ethnic/racial populations</p> <ul style="list-style-type: none"> <li>• Basic elements of a culturally competent system of care</li> </ul>	<p>diverse cultures in normal developmental settings in their own communities</p>
Skills	<ul style="list-style-type: none"> <li>• The science of using interpreters/cultural advocates Accessibility and delivery of quality care for patients to mental health services and other supportive resources</li> <li>• Collaboration with cultural healers and tribal elders within diverse cultures - their influence in explanations of illness, and in treatment and management</li> </ul>	<ul style="list-style-type: none"> <li>• Didactic sessions</li> <li>• Readings and literature review on latest evidence-based practices</li> <li>• Supervised interviews with presence of interpreters</li> <li>• Field trips to local mental health agencies specific for different ethnic groups</li> <li>• Field rotations in community agencies and systems of care</li> <li>• Lectures by community representatives</li> </ul>
Attitudes	<ul style="list-style-type: none"> <li>• Competent cross-cultural communication</li> <li>• Team approach to assessment and management that includes patient, family and other important members</li> </ul>	<ul style="list-style-type: none"> <li>• 'Expert' supervision</li> <li>• Modeling by 'expert' faculty</li> <li>• Field rotations in community agencies and systems of care</li> </ul>

### Film Resources for all objectives:

*The Visitor*

*Under the Same Moon*

*Tortilla Soup*

*Good Fences*

*The Gods Must Be Crazy*

*The Scent of Green Papaya*

*The Killing Fields*

*El Norte*

*Ma Vie en Rose*

*And the Earth Did Not Swallow Him*

*Thank You for Not Smoking*

*Mad Hot Ballroom*

*Hotel Rwanda*

*CAMP*

*Bend It Like Beckham*

*Elephant*

*Maria Full of Grace*

*Super Size Me*

*The Debut*

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# **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

*Santitos*

*Monsoon Wedding*

*The Laramie Project*

*Invisible Children*

*Color of Paradise*

*Born into Brothels*

*Beauty Academy of Kabul*

*Real Women Have Curves*

# **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

## **GOALS LISTED BY THE SIX CORE COMPETENCIES**

### **Clinical Science**

#### **Goal 1**

- Define cultural competence.
- Recognize culture as a broad concept that goes beyond the focus on the study of racial/ethnic identities and includes sub cultures of religion, economic strata, Western/mainstream medicine, patient role, intergenerational conflict etc.
- Recognize disparities in mental healthcare.
- Describe differential risk factors, diagnostic patterns, and symptom expression in different ethnic groups, including culture-bound syndromes.
- Assess a patient using a cultural formulation.
- Conduct a mental status exam from a culturally-informed perspective.
- Formulate a diagnosis that includes the cultural dimensions relevant to clinical issues and psychopathology.
- Give attention to physical appearance, affect, behaviors and behavioral norms, language and self image as being culturally determined.

#### **Goal 2**

- Describe normal developmental differences and developmental expectations among diverse populations and how these influence normal behavior.
- Describe the roles that cultural values and cultural explanatory models of mental illness play in illness expression and help-seeking behaviors.
- Articulate factors that contribute to misassessment and misdiagnosis of normative and dysfunctional behaviors in evaluating diverse children and youth.
- Describe differences in definition of roles, boundaries, and function of families across different cultures.
- Describe differences in child-rearing practices across different cultures.
- Articulate the importance of culture in the process of normal identity formation.
- Describe impact of spirituality in the process of development.
- Use the knowledge of cultural explanatory models of mental illness and the roles that these play in illness expression and help-seeking behaviors in everyday patient interactions.
- Assist diverse families in navigating the acculturation of their children and avoiding inter-generational cultural conflict.
- Recognize physician biases around normal development, family organization, and child-rearing practices and keep them in check so they do not influence clinical judgment.
- Develop an acceptance of variants in development, family organization, and child-rearing while maintaining value neutrality.
- Appreciate the challenges of bicultural identity formation.
- Appreciate the adverse impact of discrimination and marginalization on identity development.

# **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

## **Goal 3**

- Name the different faith healers that different ethnic groups commonly use in adjunction to other treatment or solely as help seeking behaviors.
- Address influence of spirituality or lack thereof in the patient's and family's understanding and management of illness.
- Discuss evidence-based practices with diverse populations.
- Discuss mental health disparities across different ethnic/racial populations, and to identify factors that contribute to their development and sustainment.
- Define the basic elements of a culturally-competent system of care.

## **Interpersonal Skills and Communication**

### **Goal 1**

- Conduct a sensitive (asking questions appropriately) psychiatric interview with the patient and family taking into account the unique cultural variables of both; not limited to ethnicity.
- Conduct a mental status exam from a culturally informed perspective.
- Use the cultural formulation in negotiating an effective psychotherapeutic and psychopharmacotherapeutic intervention with an understanding of possible differences in treatment expectations and outcome.
- Acquire proficiency in ongoing communication across cultural differences between clinician and patient-family.
- Respectfully and effectively communicate healthcare information with diverse patient population.
- Develop a therapeutic relationship with a culturally different patient.
- Effectively keep own internal biases in check to establish an objective, patient and family-centered therapeutic perspective.

### **Goal 2**

- Describe normal developmental differences and developmental expectations among diverse populations and how these influence normal behavior.
- Describe the roles that cultural values and cultural explanatory models of mental illness play in illness expression and help-seeking behaviors.
- Articulate factors that contribute to misassessment and misdiagnosis of normative and dysfunctional behaviors in evaluating diverse children and youth.
- Recognize physician biases and keep them in check so they do not influence clinical judgment.
- Develop a sensitivity to the common cultural norms of various ethnic groups.
- Develop an acceptance of variants in development, family organization, and child-rearing while maintaining value neutrality.
- Appreciate the challenges of bicultural identity formation.
- Appreciate the adverse impact of discrimination and marginalization on identity development.
- Articulate the importance of culture in the process of normal identity formation.

## **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

- Describe impact of spirituality in the process of development.
- Use the knowledge of cultural explanatory models of mental illness and the roles that these play in illness expression and help-seeking behaviors in everyday patient interactions.
- Distinguish normal variants versus dysfunctional behaviors within a cultural context.
- Effectively help diverse families recognize and address parenting practices that are not legally acceptable in mainstream American society.
- Assist diverse families in navigating the acculturation of their children and avoiding inter-generational cultural conflict.
- Develop an acceptance of variants in development, family organization, and child-rearing while maintaining value neutrality.
- Appreciate the challenges of bicultural identity formation.
- Appreciate the adverse impact of discrimination and marginalization on identity development.

### **Goal 3**

- Be aware of the local social world of the patient and family and its influence on help-seeking behavior, illness manifestation and treatment.
- Effectively use interpreters for non-English speaking patients.
- Incorporate the local social world of the patient and family in the treatment plan.
- Address influence of spirituality or lack thereof in the patient's and family's understanding and management of illness.
- Ability to pursue a culturally-competent informed consent and psychoeducational process for both pharmacotherapy and psychological/psychosocial services involving families and youth.
- Display a willingness to negotiate treatment to incorporate cultural variables and the patient's local world.
- Utilize a "team" approach to care incorporating family's beliefs about illness and treatment as well as other modalities of treatment sacred to the patient (within clinical judgment).

### **Patient Care**

#### **Goal 1**

- Recognize culture as a broad concept that goes beyond the focus on the study of racial/ethnic identities and includes sub cultures of religion, economic strata, Western/mainstream medicine, patient role, intergenerational conflict, etc.
- Define physician role in culturally-competent patient care.
- Assess a patient using a cultural formulation.
- Conduct a sensitive (asking questions appropriately) psychiatric interview with the patient and family taking into account the unique cultural variables of both; not limited to ethnicity.
- Conduct a mental status exam from a culturally informed perspective.

## **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

- Formulate a diagnosis that includes the cultural dimensions relevant to clinical issues and psychopathology.
- Give attention to physical appearance, affect, behaviors and behavioral norms, language and self-image as being culturally determined.
- Use the cultural formulation in negotiating an effective psychotherapeutic and psychopharmacotherapeutic intervention with an understanding of possible differences in treatment expectations and outcome.
- Acquire proficiency in ongoing communication across cultural differences between clinician and patient-family.
- Respectfully and effectively communicate healthcare information with diverse patient population.
- Appreciate need for cultural competency in clinical encounter.
- Develop a therapeutic relationship with a culturally different patient.
- Be comfortable with interface of his/her own personal values and socio-cultural background and cross-cultural patient care.
- Be aware of patient's and family's prejudices and biases, how they may affect clinical judgment.
- Effectively keep own internal biases in check to establish an objective, patient and family-centered therapeutic perspective.

### **Goal 2**

- Describe normal developmental differences and developmental expectations among diverse populations and how these influence normal behavior.
- Describe the roles that cultural values and cultural explanatory models of mental illness play in illness expression and help-seeking behaviors.
- Articulate factors that contribute to misassessment and misdiagnosis of normative and dysfunctional behaviors in evaluating diverse children and youth.
- Describe differences in definition of roles, boundaries, and function of families across different cultures.
- Describe differences in child-rearing practices across different cultures.
- Articulate the importance of culture in the process of normal identity formation.
- Describe impact of spirituality in the process of development.
- Use the knowledge of cultural explanatory models of mental illness and the roles that these play in illness expression and help-seeking behaviors in everyday patient interactions.
- Assist diverse families in navigating the acculturation of their children and avoiding inter-generational cultural conflict.
- Recognize physician biases around normal development, family organization, and child-rearing practices and keep them in check so they do not influence clinical judgment.
- Develop an acceptance of variants in development, family organization, and child-rearing while maintaining value neutrality.
- Appreciate the challenges of bicultural identity formation.

## **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

- Appreciate the adverse impact of discrimination and marginalization on identity development.

### **Goal 3**

- Name existing community resources available for the various ethnic groups of patients.
- Effectively use interpreters for non-English speaking patients.
- Incorporate the local social world of the patient and family in the treatment plan.
- Address influence of spirituality or lack thereof in the patient's and family's understanding and management of illness.
- Integrate the spiritual world of patient and family in the treatment plan.
- Discuss evidence-based practices with diverse populations.
- Use natural cultural and community strengths/resources within a systems of care model.
- Ability to pursue a culturally competent informed consent and psychoeducational process for both pharmacotherapy and psychological/psychosocial services involving families and youth.

### **Practice-Based Learning and Improvement**

#### **Goal 1**

- Define cultural competence.
- Define physician role in culturally-competent patient care.
- Learn about specific characteristics of normality and distress in ethnic groups in community clinician serves.
- Assess a patient using a cultural formulation.
- Give attention to physical appearance, affect, behaviors and behavioral norms, language and self image as being culturally determined.

#### **Goal 2**

- Describe normal developmental differences and developmental expectations among diverse populations and how these influence normal behavior.
- Describe the roles that cultural values and cultural explanatory models of mental illness play in illness expression and help-seeking behaviors.
- Articulate factors that contribute to misassessment and misdiagnosis of normative and dysfunctional behaviors in evaluating diverse children and youth.
- Describe differences in definition of roles, boundaries, and function of families across different cultures.
- Describe differences in child-rearing practices across different cultures.
- Describe impact of spirituality in the process of development.
- Distinguish normal variants versus dysfunctional behaviors within a cultural context.
- Recognize physician biases around normal development, family organization, and child-rearing practices and keep them in check so they do not influence clinical judgment.
- Develop a sensitivity to the common cultural norms of various ethnic groups.
- Develop an acceptance of variants in development, family organization, and child-rearing while maintaining value neutrality.

# **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

- Appreciate the challenges of bicultural identity formation.
- Appreciate the adverse impact of discrimination and marginalization on identity development.

## **Goal 3**

### **Professionalism and Ethical Behavior**

#### **Goal 1**

- Respectfully and effectively communicate healthcare information with diverse patient population.
- Value diversity and all cultural orientation as valid except when they violate basic human rights.
- Be comfortable with interface of his/her own personal values and socio-cultural background and cross-cultural patient care.
- Effectively keep own internal biases in check to establish an objective, patient and family-centered therapeutic perspective.

#### **Goal 2**

- Articulate factors that contribute to misassessment and misdiagnosis of normative and dysfunctional behaviors in evaluating diverse children and youth.
- Recognize physician biases and keep them in check so they do not influence clinical judgment.
- Reflect on his/her own cultural background/identity.
- Recognize transference and countertransference reactions related to cultural identity.
- Recognize physician biases around normal development, family organization, and child-rearing practices and keep them in check so they do not influence clinical judgment.
- Develop an acceptance of variants in development, family organization, and child-rearing while maintaining value neutrality.

#### **Goal 3**

- Display a willingness to negotiate treatment to incorporate cultural variables and the patient's local world.
- Utilize a "team" approach to care incorporating family's beliefs about illness and treatment as well as other modalities of treatment sacred to the patient (within clinical judgment).
- Adopt a value neutral approach around traditional versus non-traditional treatment selection by the family within the system of care.

### **Systems-Based Practice**

#### **Goal 1**

#### **Goal 2**

- Articulate factors that contribute to misassessment and misdiagnosis of normative and dysfunctional behaviors in evaluating diverse children and youth.
- Use of cultural explanatory models in patient interactions.

## **Diversity and Cultural Competency Curriculum for Child and Adolescent Psychiatry Training**

- Help families with parenting practices of U.S. culture vs. their own.
- Help families in negotiating acculturation.
- Use the knowledge of cultural explanatory models of mental illness and the roles that these play in illness expression and help-seeking behaviors in everyday patient interactions.
- Effectively help diverse families recognize and address parenting practices that are not legally acceptable in mainstream American society.
- Assist diverse families in navigating the acculturation of their children and avoiding inter-generational cultural conflict.
- Develop a sensitivity to the common cultural norms of various ethnic groups.
- Develop an acceptance of variants in development, family organization, and child-rearing while maintaining value neutrality.
- Appreciate the adverse impact of discrimination and marginalization on identity development.

### **Goal 3**

- Name existing community resources available for the various ethnic groups of patients.
- Name the different faith healers that different ethnic groups commonly use in adjunction to other treatment or solely as help seeking behaviors.
- Name the various psychosocial agencies existing within their communities.
- Be aware of the local social world of the patient and family and its influence on help-seeking behavior, illness manifestation and treatment.
- Effectively use interpreters for non-English speaking patients.
- Incorporate the local social world of the patient and family in the treatment plan.
- Integrate the spiritual world of patient and family in the treatment plan.
- Advocate for accessibility and delivery of quality care to mental health services and other supportive resources, such as to primary care, education, financial assistance, juvenile justice, child welfare and natural helpers for all patients.
- Discuss mental health disparities across different ethnic/racial populations, and to identify factors that contribute to their development and sustainment.
- Define the basic elements of a culturally-competent system of care.
- Use natural cultural and community strengths/resources within a systems of care model.
- Ability to pursue a culturally competent informed consent and psychoeducational process for both pharmacotherapy and psychological/psychosocial services involving families and youth.
- Display a willingness to negotiate treatment to incorporate cultural variables and the patient's local world.
- Utilize a "team" approach to care incorporating family's beliefs about illness and treatment as well as other modalities of treatment sacred to the patient (within clinical judgment).
- Adopt a value neutral approach around traditional versus non-traditional treatment selection by the family within the system of care.

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