A Four-Year Model Curriculum on Culture, Gender, LGBT, Religion, and Spirituality for General Psychiatry Residency Training Programs in the United States

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Submitted to AADPRT for consideration for consideration for as a model curriculum on Cultural Psychiatry, Friday, February 5, 2010

Revised May 3, 2010

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Introduction

The increasing cultural diversity of the United States, as shown by the most recent U.S. Census data, requires that clinicians understand how cultural differences affect diagnosis and treatment. Between 1980 and 2000, the number of Asian Americans increased by 230%, American Indians by 139%, Hispanic Americans by 142%, and African Americans by 32%. In contrast, the Caucasian population increased by 11% (1). In addition, Accreditation Council of Graduate Medical Education (ACGME) requirements for psychiatric residents now include a familiarity with cultural assessment (2), and the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR) has added new emphasis to the influence of culture on diagnosis by including an Outline for Cultural Formulation (OCF) and a Glossary of Culture Bound Syndromes (3).

Recent publications, such as the Surgeon General's Supplement to the Report on Mental Health, "Culture, Race, and Ethnicity"(2001) (4), which states that "culture counts," and the Institute of Medicine's Unequal Treatment (2002) (5) indicate that ethnic minority patients have less access to services and receive a lower quality of medical and psychiatric treatment. Other documents such as the Culturally and Linguistically Appropriate Services (CLAS) Standards (fourteen system standards about culturally competent care, language access services and organizational supports for cultural competence) (6); the Center for Mental Health Services (CMHS) report, Managed Mental Health Care Services for Four Underrepresented/Underserved Groups, (7); the California Endowment's reports Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals – 2003 (8), A Manager's Guide to Cultural Competence Education for Health Care Professionals – 2003 (9), and

Resources in Cultural Competence Education for Health Care Professionals – 2003 (10); the Commonwealth Fund Report (11); and the Clinical Manual of Cultural Psychiatry (12) suggest ways in which we can train health and mental health professionals to provide and to design culturally competent services, including evaluation of such services that are appropriate for underserved patients.

Background Information and History

We believe that the success of our cultural curriculum has been due to three factors: 1) A critical mass of committed ethnic minority faculty, 2) a supportive administration, and 3) a diverse patient population. The Diversity Advisory Committee (DAC) was founded in 1999 by its current Chair, Russell Lim, MD, to address and develop diversity issues within the UC Davis Department of Psychiatry and Behavioral Sciences. Our goals were to improve instruction in cultural competence in graduate and undergraduate medical education; improve services for ethnic minority patients by recruiting minority medical students, residents, and faculty; and to encourage scholarly work such as publications and research. DAC has also supported the development of a four-year Religion and Spirituality curriculum for the general psychiatry residency program, which received a Templeton Foundation Curricular Award in 2003, as part of a four-year Cultural Psychiatry curriculum. The American College of Psychiatrists (ACP) awarded its Creativity in Psychiatric Education in 2007 to the UC Davis Department of Psychiatry and Behavioral Sciences for the Diversity Advisory Committee. We have at least two Grand Rounds Speakers per year who present on issues in cultural psychiatry. Finally, we have conducted four successful Continuing Medical Education (CME) symposiums in the last nine years, co-sponsored a fifth last year, as well as a Faculty

Development Seminar that was held jointly with the University of California, San Francisco, on cultural psychiatry topics.

Our other goals have been to recruit minority undergraduates, medical students, residents and faculty to join the UC Davis School of Medicine and become teachers of cultural psychiatry. We are active in interviewing medical school applicants, residency applicants, and faculty applicants. DAC actively recruits residents to apply for the American Psychiatric Association (APA) Minority Fellowships, and we have had ten fellows in the last eleven years. We were also successful in recruiting Francis G. Lu, MD to be the Luke and Grace Kim Endowed Professor in Cultural Psychiatry.

Finally, DAC encourages academic scholarship. Members of DAC have received grants for research in geriatrics, and medical education and have published three articles and an editorial in a special issue of Academic Psychiatry on Culture and Psychiatric Education, and one in Adolescent Psychiatry, and have authored numerous book chapters, as well given presentations nationally. Three of our members have been honored for their contributions with the UC Davis Chancellor's Award for Diversity and Community.

The second key is administrative support. Our Chairman, Robert E. Hales, MD, MBA, has been supportive from the beginning, by providing both a budget for our grand rounds speakers, and providing us a seat on the Psychiatric Academic Council, which oversees the academic mission of the department. The Residency Training Director (Mark E. Servis, MD) has been equally supportive by allowing us to develop new required courses in the Residency program. DAC now has several representatives on the Training and Education Committee (TEC), which oversees residency training, including

curriculum. However, no program can be successful without a core group of faculty. DAC is an integral part of the infrastructure of the UCD Department of Psychiatry and Behavioral Sciences and provides needed support for critical programs. Finally, DAC is also an important part of the Dean's Council on Diversity, and we hope to bring more cultural competence to the medical center and medical school. DAC holds an annual retreat in August to review goals from the previous year and to set goals for the next. DAC meets monthly to encourage scholarly work and develop our projects agreed upon at the annual retreat.

The clinical population in Sacramento County lends relevance to our educational programs with its wide diversity of languages and cultures represented. For example, an article in Time magazine called Sacramento the most diverse city in the United States in September of 2002 (13). Sacramento County has seven threshold languages (Cantonese, Hmong, Lao, Mien, Russian, Spanish, Vietnamese), as defined by the California Cultural Competence Plan (14) as 5% of the Medicaid population or 3000 members, that speak that language, which is second only to Los Angeles County, which has eight. Yet few of the department's educational activities in 1998 addressed the issues of how to serve a culturally diverse population. We now feel that we can design and deliver a cultural curriculum that can develop attitudes that support culturally competent care, teach important cultural specific knowledge, and encourage the development of culturally generic skills that lead to culturally appropriate assessment and treatment. Other programs should perform a similar needs analysis of their patient population prior to implementing a cultural competence curriculum, and make changes as their needs are discovered and their resources are identified and developed.

Our approach can be stated simply as four guiding principles: 1) teach attitudes that value acceptance of diverse cultural beliefs and worldviews, 2) demonstrate skills that are culture generic, 3) teach knowledge that is culture specific, and 4) teach culturally adapted techniques that are supported by evidence in peer-reviewed journals. The sources for our inspiration are many, and this model curriculum represents the best of what we have created in other settings added on to the original ACP award-winning curriculum. We owe a great debt to the dedicated teachers that served as faculty in the APA Annual Meeting Continuing Medical Education (CME) course entitled DSM-IV Cultural Formulations: Assessment and Treatment, that the first author (RFL) directed annually for thirteen years that led to the publication of the book Clinical Manual of Cultural Psychiatry, which was based on the assumption that the use of the DSM-IV OCF, along with culturally based knowledge would help to develop cultural competence. We also acknowledge material developed and inspired by Sunita Mutha and Mary Walton in their annual seminar at UCSF, Addressing Health Disparities: Cultural Competency Faculty Development Program (15), which in turn inspired our second APA Annual Meeting CME Course, Culturally Appropriate Assessment Made Incredibly Clear- A Skills-based Course with Hands-On Experiences.

While the UC Davis cultural psychiatry curriculum is designed to be relevant for the culturally diverse patient population seen by our general psychiatry residents, we acknowledge there are inadequacies. To generalize its use in other general psychiatry residency programs, as well as address under-represented topics, we have added sections on Native American and LGBT topics to our model. The limitations to applying our curriculum are that the curriculum should be tailored to the patient population seen, and

be taught by faculty experienced with working with the identified ethnic groups.

Teaching all of the included material may exceed the available time in the residency curriculum. In that case, we would suggest the prioritization of mental health disparities, attitude development, skills development, general informational sessions, and cultural formulation presentations. We would also suggest prioritizing the films, perhaps omitting most films except The Color of Fear, in the most time-limited scenario. Some of the psychotherapy material may be incorporated in a case conference format using the DSM-IV-TR OCF, which would not take up any extra curricular time, as case conferences are not thought of as being part of the formal didactic curriculum.

References

(1) CensusScope: 2000, http://www.censusscope.org/us/chart_race.html , accessed February 5, 2010

(2) Accreditation Council of Graduate Medical Education: ACGME Program Requirements for Graduate Medical Education in Psychiatry 2007. http://www.acgme.org/acWebsite/downloads/RRC_progReq/400pr07012007.pdf, accessed February 6, 2008

(3) American Psychiatric Association: Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR), APA, Washington, DC, 2000

(4) United States Department of Health and Human Services: Culture, Race, and Ethnicity: A Supplement to Mental Health a Report of the Surgeon General, 2001, http://www.surgeongeneral.gov/library/mentalhealth/cre/, accessed February 5, 2010

(5) Smedley BD, Stith AY, Nelson AR: Unequal Treatment: What Health Care Providers Need to Know About Racial and Ethic Disparities in Healthcare. National Academy Press, 2002, http://www.nap.edu/catalog/10260.html, accessed February 5, 2010

(6) Office of Minority Health: Culturally and Linguistically Appropriate Services (CLAS) standards, 2000, http://www.omhrc.gov/clas/indexfinal.htm, accessed February 5, 2010

(7) SAMHSA: Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. SMA00-3457, 2001, http://mentalhealth.samhsa.gov/publications/allpubs/SMA00-3457/preface.asp, accessed February 5, 2010

(8) California Endowment: Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals – 2003a,

http://www.calendow.org/Collection_Publications.aspx?coll_id=26&ItemID=316, click "View Report" below description, accessed February 5, 2010

(9) California Endowment: A Manager's Guide to Cultural Competence Education for Health Care Professionals. 2003b, http://www.calendow.org/Collection_Publications.aspx?coll_id=26&ItemID=316, click "View Report" below description, accessed February 5, 2010

(10) California Endowment: Resources in Cultural Competence Education for Health Care Professionals. 2003c, http://www.calendow.org/Collection_Publications.aspx?coll_id=26&ItemID=316, click "View Report" below description, accessed February 5, 2010

(11) Betancourt, JR Green AR, Carrillo JE: Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches. The Commonwealth Fund, October 2002, http://www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf, accessed February 05, 2010

(12) Lim RF, ed.: Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI, 2006

(13) Stodghill R, and Bower A: Welcome to America's Most Diverse City. Time, Sunday, August 25, 2002, http://www.time.com/time/nation/article/0,8599,340694,00.html, accessed February 3, 2010

(14) [California] DMH (Department of Mental Health) Information Notice No: 02-03. Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services -- Cultural Competence Plan Requirements; 2003, superseding [California] DMH Information Notice No: 97-14. Addendum for implementation plan for phase II consolidation of Medi-Cal specialty mental health services--cultural competence plan requirements, 1997. http://www.dmh.cahwnet.gov/DMHDocs/docs/notices02/02-03_Enclosure.pdf, accessed February 16, 2008

(15) Mutha S, Walton N: Addressing Health Disparities: Cultural Competency Faculty Development Program, https://www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MMC09019, accessed February 4, 2010

Goals:

1. To fulfill 2007 ACGME RRC accreditation standards for general psychiatry residency programs that focus on sociocultural issues (underlined and in italics) for five of the six core competencies as follows:

1) Patient care

a) "Residents must have supervised experience in the evaluation and treatment of patients. *These patients should be of different ages and gender from across the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds*."

b) "Residents should develop competence in formulating a clinical diagnosis for patients by conducting patient interviews, eliciting a clear and accurate history; performing physical, neurological, and mental status examination, including appropriate

diagnostic studies; completing a systematic recording of findings; *relating history and clinical findings to* the relevant biological psychological, behavioral, and *sociocultural issues associated with etiology and treatment*"

2) Medical knowledge

"The didactic curriculum must include the following specific components:"

a) "the biological, genetic, psychological, *sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors* that significantly influence physical and psychological *development throughout the life cycle*"

b) "the fundamental *principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders* in the current standard diagnostic statistical manual, including the biological, psychological, *sociocultural*, and iatrogenic *factors that affect the prevention, incidence, prevalence and long-term course and treatment of psychiatric disorders and conditions*"

c) "an understanding of American culture and subcultures, particularly those found in the patient community associated with the educational program, with *specific focus for residents with cultural backgrounds that are different from those of their patients*"

d) "[the] use of *case formulation* that includes neurobiological, phenomenological, psychological, and *sociocultural issues involved in diagnosis and management of cases*"

3) Interpersonal and communication skills

a) "Residents are expected to…. *communicate effectively* …, with patients, their families, and the public across a broad range of socioeconomic and cultural backgrounds"

b) "[Residents need to proficient at] *demonstrating sensitivity and responsiveness* to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation"

4) Professionalism

a) "Residents are expected to demonstrate… *sensitivity and responsiveness* to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation."

5) Systems-based practice

a) "Residents are expected to *advocate for quality patient care and assisting patients in dealing with system complexities, including disparity in mental health care*"

Summarizing, our goals are:

1. To have trainees understand the impact of culture on assessment/formulation,

diagnosis and treatment of mental disorders

2. To improve treatment outcomes of all patients by effectively bridging the patient's worldview and the clinician's treatment plan and collaborating with the patient's social network

3. To reduce mental health disparities by teaching trainees specific skills and knowledge to effectively treat all under-served groups

Objectives:

Skills:

Year One-Introduction to Cultural Psychiatry

1. To understand one's own cultural identity

Year Two-Cultural Psychiatry

2. To able to use the DSM-IV-TR OCF to inform the clinical interview, which includes many of the goals listed below
3. To assess a cultural identity
4. To assess an explanatory model
5. To assess religious/spiritual issues relevant to patient care
6. To interview patients regarding their spiritual/religious values, beliefs, and practices with empathy and sensitivity, and incorporate religious, spiritual and cultural issues in the differential diagnosis, case formulation and treatment plan of patients when appropriate
7. To assess cultural stressors and supports
8. To assess the culture elements of the relationship between the patient and clinician
9. To be able to use an interpreter effectively
10. To be able to recognize the impact of culture on symptom presentation and assessment
11. To be able to recognize the impact of culture on treatment planning

Year Three-Psychotherapy and Culture

12. To understand how to adapt cognitive therapy and supportive therapy to underserved populations, such as Cambodians and Hispanics

Year Four- Advanced Cultural Psychiatry

13. To write and present a case presentation using the DSM-IV-TR OCF
14. To be able to use a cultural consultant

Attitudes:

Year One

1. To understand their own cultural identity
2. To begin to understand one's own cultural systems
3. To develop awareness and acceptance of differences between their own worldview and those of others

4. To understand how to take a spiritual/religious history and when to ask for a more thorough assessment
5. To be aware of one's own spiritual experiences and values, and be willing to overcome personal biases and discomfort in addressing spiritual/religious issues in patient care
6. To appreciate spiritual and religious diversity of their patients and colleagues, while being sensitive and responsive of patients from a variety of religious and spiritual backgrounds
7. To be respectful of the services provided by chaplains, clergy, and spiritual leaders, including a willingness to collaborate in the medical and emotional care of patients who are ill and/or dying, and their families
8. To understand the culture of medicine and its impact on one's work and life

Year Two

9. To understanding the impact of racism, sexism, heterosexism, and religious bias on patient's lives

Knowledge: To understand the following topic areas

Year One

Introduction to spirituality and religion in psychiatry

1. The various ways of defining the terms "spiritual" and "religious"
2. The research data on spiritual and religious beliefs and practices on health care, especially mental health
3. The spiritual and religious worldviews that may be harmful or distorted, and determine appropriate interventions and referrals
4. Approaches to critically assess and discuss the methodologies and conclusions of the research data on spirituality and health care

Year Two-A Background History for Cultural Competence

1. Describe disparities in mental health treatment based on ethnicity
2. Definitions of common terms such as cultural competence, diversity, culture, race, ethnicity, linguistic access, mental health and healthcare disparities
3. Use primary sources to describe the evidence for mental health and healthcare disparities
4. Describe pertinent national and state regulations and policies regarding culturally and linguistically appropriate health care and services (i.e., USDHHS, Office of Minority Health (CLAS), Office of Civil Rights, LEP)
5. Describe how culture shapes health beliefs and values
6. Describe how culture affects help-seeking behaviors and decision-making
7. Discuss how cross-cultural communication and medical

interpreters can affect the use of health services and outcomes

8. Rationale for using an interpreter
    a. Improving the quality of care
    b. Better health outcomes
    c. Compliance with legal regulations (i.e., Title VI of the Civil Rights Act)
9. The resident will learn culture specific knowledge about patient populations generally seen, such as historical facts such as reasons for immigration, and basic cultural beliefs and cultural gender and family roles, as well as differing cultural presentations of illness and culture bound syndromes concerning:
    a. African Americans
    b. Asian Americans
    c. Hispanic Americans
    d. Native Americans
    e. LGBT individuals
    f. Women's' Health and Mental Health
10. The effect of race/ethnicity on pharmacology
11. Cultural aspects of depression

Year Three

12. Understand how to formulate psychotherapy cases by stages of acculturation, racial identity, self identity, and communication styles
13. Learn psychotherapy techniques to use with patients from diverse cultures
14. Be able to identify intra-ethnic and inter-ethnic transference and counter transference
15. The effect of race/ethnicity, gender, and sexual orientation, amongst other cultural identity variables in psychotherapy with:
    a. African Americans
    b. Asian Americans
    c. Hispanic Americans
    d. Native Americans
    e. LGBT individuals
    f. Women

Spiritual/religious issues in psychotherapy

1. Recognize when exploration of spiritual/religious issues may be valuable
2. Understand the difference between healthy and normative spiritual or religious phenomenon from that which is unhealthy and psychopathological
3. Understand the value of patients' spirituality/religion as a source of strength/support and positive coping, versus a source of stress and negative coping

4. Understand types of transference and counter-transference that may occur when exploring spiritual and religious issues with patients, and its effect upon therapy
5. Interview patients regarding their spiritual or religious values, beliefs, and practices with empathy and respect
6. Incorporate spiritual/religious issues in the differential diagnosis, case formulation, and treatment plan of patients, when appropriate
7. Address issues of transference and counter-transference, and determine appropriate interventions, including when the therapist's religious/spiritual affiliations are questioned
8. Be aware of one's own spiritual/religious experiences and values, and how it may influence their consideration of the spiritual/ religious issues of patients
9. Recognize when patients may benefit from either further spiritual/religious assessment and from utilizing religious or spiritual resources, including referral to clergy or pastoral counseling

Advanced Cultural Psychiatry- PGY-4

1. The resident will be able to write and present a case in the DSM -IV-TR OCF.
2. The resident will be able to use a cultural consultant to further explore a case from his or her own caseload.

Bibliography-Resources

1. Accreditation Council for Graduate Medical Education: Residency Review Committee, Guidelines for Psychiatric Residencies, 2007. Available at www.acgme.org/acWebsite/downloads/RRC_progReq/ 400pr07012007.pdf, 2007
2. SAMHSA: Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups, http://mentalhealth.samhsa.gov/publications/allpubs/sma00-3457/, 2001
3. Smedly BD, Stith AY, Nelson AR (Eds.): Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press. 2003
4. Lurhmann TM: Of Two Minds: An Anthropologist Looks at American Psychiatry. New York, NY: Random House, 2001
5. Pinderhughes E: Understanding Race, Ethnicity, and Power: The Key to Efficacy on Clinical Practice. New York, NY: Free Press, 1989
6. Koenig H: Spirituality in Patient Care: Why, How, When, and What, 2nd Edition, Philadelphia, PA: Templeton Foundation Press, 2006
7. Koenig, HG and Sloan, RP. Pro & Con: Should physicians conduct spiritual histories of their patients? Clinical Psychiatric News, Volume 32, Issue 3, Page 20, 2004
8. Pulchalski C: Spiritual assessment in clinical practice. Psychiatric Annals,

36: 150-5, 2006
9. Lim RF, Lu FG, Hilty DM: The Impact of Social Inequalities on Health Care. In Behavior and Medicine, 5th Edition, In Wedding D, Stuber ML, (Eds.) Cambridge, MA: Hogrefe and Huber, 2010
10. Lim RF: The Role of Cultural Competence. In Ruiz P, Primm A, (Eds.) Disparities in Psychiatric Care: Clinical and Cross-Cultural Perspectives. Philadelphia, PA: Wolters Kluwer/Lippincott, Williams and Wilkens, 2010
11. Brach C, Fraserirector I: Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Medical Care Research Review, *57* (Suppl), 181–217, 2000
12. USDHHS: Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: USDHHS, Public Health Service, Office of the Surgeon General, 2001
13. American Psychiatric Association: Appendix I: Outline for cultural formulation and glossary of culture-bound syndromes, in American Psychiatric Association: Diagnostic and Statistical Manual, 4th Ed, Text Revision. Washington, DC: APA, 2000, pp 897–903
14. Lim RF, (Ed.): Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI, 2006
15. Lim RF, Kramer EJ: Culturally Informed Mental Health Assessment: Using the DSM-IV-TR Outline for Cultural Formulation, Davis, CA: UC Davis Department of Psychiatry and Behavioral Sciences, 2010
16. Kleinman A, Eisenberg L, Good B: Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med 88: 251-258, 1978
17. Adebimpe VR: Overview: white norms and psychiatric diagnosis of black patients. Am J Psychiatry; 138:279-285, 1981
18. Lim RF, Ton H: Depression and culture: Implications for the assessment and treatment of patients of diverse ethnicities. Depression: Mind and Body, 4:2; 42-50, 2008
19. Association of Gay and Lesbian Psychiatrists and Group for the Advancement of Psychiatry, LGBT (Lesbian, Gay, Bisexual, and Transgender) Curriculum, http://www.aglp.org/gap/, accessed, January 31, 2010
20. Lim RF, Diamond RJ, Chang JB, Primm AB, Lu FG: Using non-feature films to teach diversity, cultural competence, and the DSM-IV-TR outline for cultural formulation. Acad Psychiatry, 32: 291-298, 2008.
21. Lee MW: The Color of Fear. Berkeley, CA: Stir Fry Productions, 1995
22. Daniel Karslake: For The Bible Tells Me So. New York, NY: First Run Features, 2007
23. PBS Video: The Pill. Alexandria, VA: PBS Video, 2003
24. PBS Video: Frontline: The Alternative Fix. Alexandria, VA: PBS Video, 2003
25. Lu FG, Koskoff H: The Culture of Emotions. Boston: Fanlight Productions, Brooklyn, NY, 2002

26. Ton H, Lim RF: The assessment of culturally diverse individuals. In Lim RF (Ed.): Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI, 2006, pp 3-42
27. Caraballo A, Hamid H, Lee JR, McQuery JD, Rho Y, Kramer EJ, Lim RF, Lu FG: A resident's guide to cultural formulation. In Lim RF (Ed.): Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI. 2006, pp 243-71
28. Hays PA: Addressing Cultural Complexities in Practice: Assessment, Diagnosis, and Therapy, 2nd edition, Washington, DC: American Psychological Association Press, 2007
29. Lee E: Cross-cultural communication: therapeutic use of interpreters. In Lee E (Ed.): Working with Asian Americans: A Guide for Clinicians. New York: Guilford. 1997, pp 477–489
30. Mutha S, Allen C, Welsh M: Toward Culturally Competent Care: A Toolbox For Teaching Communication Strategies. San Francisco, CA: UCSF Center for the Health Professions. 2002
31. Primm AB: Issues in the assessment and treatment of African-American patients. In Lim RF (Ed.): Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI. 2006, pp 35-68
32. Du N: Issues in the assessment and treatment of Asian-American patients. In Lim RF (Ed.): Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI, 2006, pp 69-117
33. Laria AJ, Lewis Fernandez R: Latino patients. In Lim RF (Ed.): Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI. 2006, pp 119-173
34. Fleming CM: American Indian and Alaska Native patients. In Lim RF (Ed.): Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI, 2006. pp 175-203
35. Smith MW: Ethnopsychopharmacology, In Lim RF (Ed.): Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI, 2006, pp 207-37
36. Culhane-Pera K, Vawter DE, Solberg MM: Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers. Atlanta, GA: Vanderbilt University Press, 2003
37. Bland I: The Cross-Cultural Therapeutic Alliance: the African-American Client: http://www.unitedlearning.com/ Distributed by United Learning (previously The Altschul Group), 1560 Sherman Ave., Suite 100, Evanston, IL 60201, 1994
38. Kinzie, JD: Psychotherapy for massively traumatized refugees: the therapist variable. American Journal of Psychotherapy, 55:475-490, 2001
39. Hinton DE, Otto MW: Symptom presentation and symptom meaning among traumatized Cambodian refugees: relevance to a somatically focused cognitive-behavioral therapy. Cognitive and Behavioral Practice, Volume 13, Issue 4, November 2006, Pages 249 - 260
40. Otto MW, Hinton DE: Modifying exposure-based CBT for Cambodian refugees with posttraumatic stress disorder. Cognitive and Behavioral Practice, Volume 13, Issue 4, November 2006, Pages 261-270
41. Interian A, Díaz-Martínez, AM: Considerations for culturally competent

cognitive-behavioral therapy for depression with Hispanic patients. Cognitive and Behavioral Practice, 14:1, 2007, Pages 84-97
42. Gone, JP: Psychotherapy and traditional healing for American Indians: Exploring the prospects for therapeutic integration. The Counseling Psychologist. 38: 2, 166-235, 2010
43. Koenig, HG and Pritchett, J. Religion and psychotherapy. In, Koenig, HG (Ed.) Handbook of Religion and Mental Health. San Diego: Academic Press, 1998
44. McAuliffe G, et al: Culturally Alert Counseling: A Comprehensive Introduction. (DVD included with book). Thousand Oaks, CA: Sage Publications, 2008
45. Romans SE and Seeman MV: Women's Mental Health: A Life Cycle Approach. Philadelphia, PA: Lippincott Williams and Wilkins, 2006
46. Arredondo P: Multicultural Counseling Video Series: Counseling Latina/Latino Clients, Washington, DC: American Psychological Association, 2005
47. Arredondo PM: Latina/Latino Counseling & Psychotherapy: Specifics of Practice for Counseling with Latina/os - North Amherst, MA: Microtraining Associates, 1994
48. Gill RM, Vasquez CI: The Maria Paradox, New York, NY: G. Putnam's Sons, 1996
49. Parham TA: Multicultural Counseling Video Series: Working With African American Clients, Washington, DC: American Psychological Association, 2005
50. Parham TA: Managing Therapeutic Issues with African-American Clients. North Amherst, MA: Microtraining Associates, 1992
51. Parham TA: Counseling Persons of African Descent: Raising the Bar of Practitioner Competence. Thousand Oaks, CA: Sage Publications, 2002
52. Lu FG: Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans. Sacramento, CA: Mental Health Association in California, 1127 11th Street, Suite 925, Sacramento, CA 95814, see http://www.mhac.org/barriers/antistigma.cfm
53. Tseng WS, Strelzer J: Culture and Psychotherapy: A Guide to Clinical Practice. Washington, DC: American Psychiatric Press, Inc., 2001
54. Bhui K, Morgan N: Effective psychotherapy in a racially and culturally diverse society, Advances in Psychiatric Treatment, 13: 187-193, 2007
55. Cardemil EV, Battle C: Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. Professional Psychology: Research & Practice, 34, 278-286, 2003
56. Comas-Diaz L, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. Am J Orthopsychiatry, 61:392–402, 1991
57. Hsu J, Tseng, WS: Intercultural psychotherapy. Archives of General Psychiatry, 27, 700–705, 1972
58. Kirmayer LJ: Psychotherapy and the cultural concept of the person. Trancult Psychiatry, 44: 232-257, 2007

59. Lewis DK: A cross-cultural model for psychotherapy: Working with the African-American client. Cultural Diversity and Ethnic Minority Psychology, 6:2, 1996
60. Poston WSC, Craine M, Atkinson DR: Counselor dissimilarity confrontation, client cultural mistrust, and willingness to self-disclose. J MultiCult Couns Dev, 19, 65-73, 1991
61. Seeley K: The listening cure: listening for culture in intercultural psychological treatments, Psychoanal Rev, Jun;92(3):431-52, 2005
62. Tummala-Narra P: Dynamics of race and culture in the supervisory encounter. Psychoanalytic Psychology, 21:2, 300–311, 2004
63. Bland IJ, Kraft IK: The therapeutic alliance across cultures. In Okpaku, S, ed., Clinical Methods in Transcultural Psychiatry. Washington, DC, APPI, 1998
64. Chin, JL: Toward a psychology of difference: psychotherapy for a culturally diverse population. In Chin JL, De La Cancela V, and Jenkins YM, Eds: Diversity in Psychotherapy: The Politics of Race, Ethnicity, and Gender, edited by. Westport, CT: Praeger Publishers, 1993
65. Foulks EF, Bland IJ, & Shervington D: Psychotherapy across cultures. In Oldham JM and Riba M (Eds.), Annual Review of Psychiatry (Vol. 14, pp. 511–528). Washington, DC: American Psychiatric Press, 1995
66. Sue DW, Sue D: Counseling the Culturally Diverse: Theory and practice, 5th Edition. New York: J. Wiley, 2007
67. Yamamoto J, Silva JA, Justice LF, Chang CY, Leong GB: Cross-cultural psychotherapy, in Gaw AC, ed, Culture, Ethnicity, and Mental Illness. Washington, DC: American Psychiatric Press, 1993
68. Lewis-Fernandez R, Diaz N: The cultural formulation: A method for assessing cultural factors affecting the clinical encounter, Psychiatric Quarterly, 73: 4, pp 271-95, 2002
69. Cheung F, Lin KM: Neurasthenia, depression and somatoform disorder In a Chinese-Vietnamese woman migrant. Culture, Medicine, and Psychiatry, 21: 247–258, 1997
70. McGoldrick M, Giordano J, Garcia-Preto N: Ethnicity and Family Therapy, 3rd Edition, New York: Guilford Press, 2005
71. Lu FG: Annotated Bibliography of Cultural Psychiatry and Other Topics, in Lim RF (ed.) Clinical Manual of Cultural Psychiatry. Arlington, VA: APPI, 2006, pp 271-290
72. Diamond M, Sigmundson HK: Sex reassignment at birth: Long-term review and clinical implications. *Arch Pediatr Adolesc Med* 15:298-304, 1997
73. Colapinto J: Gender Gap: What were the real reasons behind David Reimer's suicide? *Slate*, June 3, 2004
74. Colapinto J: The true story of John/Joan. *Rolling Stone*; Dec 11, 54-97. (available at http://www.infocirc.org/rollston.htm), 1997
75. Tyson P: A developmental line of gender identity, gender role, and choice of love object. *J Amer Psychoanal Assn* 30:61-80, 1982
76. Cahill L: Why sex matters for neuroscience. *Nature Reviews Neuroscience* 7:477-484, 2006

77. Hampton T: Researchers tap into the male brain. *JAMA* 296:2301-2302, 2006
78. Atkinson S, Gabbard GO: Erotic transference in the male adolescent-female analyst dyad. *Psychoanal St Child* 50:171-186, 1995
79. Hobday G, Mellman L, Gabbard GO: Complex sexualized transferences when the patient is male and the therapist female. *Am J Psych* 165:1525-30, 2008
80. Gabbard GO: Sexual excitement and countertransference love in the analyst. *J Amer Psychoanal Assn* 42:1083-1106, 1994
81. Person E: Transference love and romantic love. In: *Dreams of Love and Fateful Encounters.* New York, Penguin Books, 1988, pp. 241-264
82. Tinsley JA, Mellman LA: Patients' reactions to a psychiatrist's pregnancy. *Am J Psych* 160:27-31, 2003
83. Mogul KM: The sex of the therapist. *Am J Psych* 139:1-11, 1982
84. World Professional Association for Transgender Health: Standards of Care (available at: http://www.wpath.org/publications_standards.cfm)
85. Soares C: The menopausal transition and depression: a window of vulnerability? *Menopause Management* March-April, 13-25, 2008
86. Goldstein SR, Stuenkel CA: The long and winding road of hormone therapy: Where are we today? *Women's Health Update*, Special supplement, March-April, 1-11, 2008

Optional readings:

87. Brizendine L: The Female Brain. NY, Morgan Road Books, 2006
88. Diamond MJ: Masculinity unraveled. *J Amer Psychoanal Assn* 54:1099-1130, 2006
89. Ulberg R, Johansson P, Marble A, Hoglend P: Patient sex as moderator of effects of transference interpretation in a randomized controlled study of dynamic psychotherapy. *Can J Psych* ; 54:78-86, 2009
90. Nadelson CC, Notman MT: Gender issues in psychiatric treatment. In Gabbard GO. (Editor): *Treatment of Psychiatric Disorders*, 3rd Ed. Arlington, VA. American Psychiatric Publishing, 2001, pp. 21-45.
91. McWilliams N: Therapy across the sexual orientation boundary: Reflections of a heterosexual female analyst on working with lesbian, gay, and bisexual patients. *Gender and Psychoanalysis* 1:203-221, 1996

Instructional Methods

1) Cultural Identity Awareness Exercise- Ask participants to first self-reflect on their current cultural identity, and then introduce themselves considering many possible cultural identity variables: where they are from, what language (s) they speak, race/ethnicity, gender, sexual orientation, socioeconomic status, educational attainment, spiritual/religious beliefs, roles that they play in their life, among others. This exercise

can also be done in pairs first by noting the cultural identity differences between the two persons. Finally, the pairs could share their cultural identity similarities and differences with others in the group. The leader(s) of this exercise may wish to model this process first to facilitate the participants' engagement. A second exercise would be for each person to self-reflect on the development of their cultural identity over time and location changes focusing on times when differences were experienced between the person and others. Then, as with the first exercise, pairs could start the process to discuss between them their experiences of differences and its impact on cultural identity development, and finally sharing can take place in the larger group. This second exercise can also be modeled first by the leader(s).

2) Lectures on cultural generic assessment techniques organized with the DSM-IV-TR OCF and discussion about cases (both published and current unpublished ones), which exemplify the use of the OCF.

A. Cultural identity of the individual with standardized patient,

B. Cultural idioms of distress, culture bound syndromes, explanatory models, and treatment pathways with standardized patient,

C. Cultural stressors and supports with standardized patient,

D. Cultural elements of the relationship between the clinician and the individual.

E. Overall assessment for differential diagnosis and treatment planning with standardized patient.

3) Lectures and discussion on culturally specific knowledge issues.

4) A journal club can supplement site-specific learning, as would case conferences using the DSM-IV-TR OCF. Residents are expected to write and present

cases incorporating the OCF.

5) Videos as a stimulus for discussion. Examples include: The Color of Fear to discuss racism (Lim, Diamond, Chang, et al), For the Bible Tells Me So, to discuss homophobia, The Alternative Fix, to discuss complimentary and alternative medicine, The Pill, to discuss women's health issues, The Culture of Emotions, to discuss the DSM-IV-TR OCF, and Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans, to discuss the stigma of mental illness in Asian Americans.

6) Videotaped case material showing a demonstration of skills, followed by a practice session with a standardized patient, followed by formative evaluation with standardized patients.

7) Online learning, such as the use of the Association of Gay and Lesbian Psychiatrists, LGBT Mental Health Syllabus at http://www.aglp.org/gap.

Instructor Preparation

Instructors must be familiar with the main concepts of cultural competence, including mental health/healthcare disparities, federal and state initiatives, and be aware of their own cultural identity and biases. All instructors should be familiar with the curricular material, and would be expected to have completed a cultural identity awareness exercise, complete reading of articles and viewing of tapes. The instructor would receive training in evaluating cultural assessment skills with the use of standardized patients. Instructors will also be given a training entitled- "A Train the Trainer's Workshop." Ideally, instructors should have clinical experience in working with culturally diverse patients including from ethnic minority groups.

Expectations of Learners

Learners are expected to approach the curriculum with an open mind, to share personal experiences with racism and other biases based on cultural identity and working with other cultural groups, to be mindful of cultural factors in all patient interactions, to read all articles prior to lecture, and to bring in case examples for discussion using the DSM-IV-TR OCF.

Creativity and Innovation

Our curriculum is comprehensive and developmental. It recognizes that culture specific knowledge is necessary but insufficient as well as potentially promoting stereotypes when it is the sole focus of the curriculum. Culture generic cultural competence skills must be demonstrated, taught, and evaluated for a minimum level of proficiency. It emphasizes the concept of "just in time" learning, or developmentally appropriate objectives which teaches the concepts at a time in their training when residents are most likely to use them, such as psychotherapy skills during the usual third year outpatient experience. The curriculum emphasizes actual performance and evaluation of skills using standardized patients in lecture and informative evaluation. We have created our own training materials with a unique set of videotaped cases using a Caucasian interviewer and standardized patients to demonstrate the use of the OCF in interviewing.

Course outlines

Two Phases:

Culture-generic skills and attitudes, then culture-specific knowledge.

Year one

Cultural identity awareness and the culture of medicine (Lurhman)

Cultural introductions
Discussion Group Questions for Cultural Identity Awareness Exercise (Modeled after E. Pinderhughes)

1. What is your cultural identity?
2. What was your first experience with feeling different?
3. What is your ethnic background?
4. What has it meant to belong to your ethnic group?
5. How has it felt to belong to your ethnic group?
6. What do you like about your ethnic identity?
7. What do you dislike?
8. What are your feelings about being White or a person-of-color?
9. How do you think others feel?

Spiritual History and Assessment- 2 sessions (Koenig, Koenig and Sloan, Pulchalski)

Year two

Rationale for cultural competence, (ACGME, RRC accreditation core competences on sociocultural issues)
Health and mental health disparities (Lim, Lu, Hilty) (Lim)
Supplement to Surgeon General's Report on Mental Health (USDHHS)
Unequal Treatment (Smedley, et al)
The business case for cultural competence (Brach, Frasierrector)
Stereotypes vs. Generalizations (Mutha, Welsch)
CLAS standards (OMH)

The DSM-IV-TR Outline for Cultural Formulation and assessment skills (APA, Caraballo, et. al., Ton, Lim)
Cultural Identity:
The "Addressing" acronym (Hays) is a good starting point for the assessment of cultural identity.

Age and generational influences
Developmental and acquired
Disabilities
Religion and spiritual orientation
Ethnicity
Socioeconomic status
Sexual orientation
Indigenous heritage
National origin
Gender

Additional cultural identity variables to consider:

1. Language (s) spoken or preferred
2. Acculturation

3. Gender/ Gender Identity
4. Ethnicity
5. Nationality
6. Sexual orientation
7. Religious or spiritual group
8. Political orientation
9. Vocational identity
10. Geographic location (i.e., rural, urban, suburban)

How? Developmental, social history, or direct questioning.
Standardized Patient exercise- Part A of OCF

Idioms of Distress

1. Dizziness
2. Fatigue
3. Pain- headaches, backaches, stomach aches
4. Evil spirits

Culture Bound Syndromes

1. Ataque de Nervios
2. Neurasthenia (Shenjing Shuairuo)

Explanatory Models (Ton, Lim)

1. Magic- Evil Eye
2. Religious- Punishment
3. Moral- Laziness, selfishness, weak will
4. Medical-Ayurveda, Chinese Traditional Medicine, Homeopathy, osteopathy, herbal treatments, etc.
5. Psychological Stress

Kleinman's Questions (Kleinman)

1. What do you call your illness? What name does it have?
2. What do you think has caused the illness?
3. Why and when did it start?
4. What do you think the illness does? How does it work?
5. How severe is it? Will it have a short or long course?
6. What kind of treatment do you think the patient should receive? What are the most important results you hope she receives from this treatment?
7. What are the chief problems the illness has caused?
8. What do you fear most about the illness?

Standardized Patient exercise- Part B of OCF

Standardized patient exercise- Part C- Cultural stressors and supports, spiritual assessment

Film example Part D- (Bland or Lim, Lu cases)

Standardized Patient exercise- Part E- Explaining the treatment plan, including the patient's explanatory model and LEARN (Caraballo, et al)

The Culture of Emotions- The DSM-IV-TR OCF (Lu, Koskoff)

The Color of Fear- Exploring feelings about racism (Lee Mun Wah)

How to use an Interpreter (Lee)
American culture-Our culture and what it means to others
Chapters from Clinical Manual of Cultural Psychiatry
    Ethnopsychopharmacology (Smith)
    African Americans (Primm)
    Asian Americans (Du)
    Hispanic Americans (Laria, Lewis-Fernandez)
    Native Americans (Fleming)
Trauma and Substance Abuse
LGBT- (AGLP- LGBT Curriculum)
    The History of Psychiatry and Homosexuality
    Taking a Sexual History with LBGT Patients
    Psychological Development & Life Cycle
    Psychotherapy
    Medical and Mental Health
    Transgender
    Intersex
    Diversity / People of Color

Russell Lim 5/4/10 1:28 AM
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Culture and Depression (Lim, Ton)

Journal club: Explanatory models (Kleinman), Racism and misdiagnosis (Adebimpe), Cognitive behavioral therapy (Otto and Hinton, Hinton and Otto), Ethnography (Culhane Pera K), PTSD and Latinos.

Formative evaluation with standardized patients and feedback on videotaped interview, focusing on verbal and non-verbal communication.

Year Three

Adapting psychotherapy techniques and assumptions (references 43-68)
Introduction to psychotherapy and culture
Definitions
Assumptions in Western psychotherapy
Acculturation
Communication and listening culturally
Norms
Techniques
Barriers to multi-cultural therapy
Communication style differences
Ethnocultural transference and counter-transference (Comas Diaz, Jacobsen)
Supervision and ethnicity (Tumula-Nara)
Identity- Racial identity and cultural self-identity
Practical clinical strategies
Culturally Alert Counseling: A Comprehensive Introduction- DVD (McAuliffe)
Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans- Lu

Video Case examples- Strategies to overcome Barriers to effective psychotherapy
Hispanic issues in psychotherapy- (Arrendondo)
The ten commandments of marianismo
Spanish phrases and metaphors
Psychotherapy and African Americans (Parham)
Rituals and symbols
"Life at its best is a creative synthesis of opposites in fruitful harmony."

Examples
Cognitive Therapy in Cambodians- (Otto and Hinton, Hinton and Otto)
` CBT in Hispanics- (Interian, Díaz-Martínez)
The therapist variable- (Kinzie)
Group therapy with Vietnamese patients- (Truong and Gutierrez)
Therapy in African Americans- (Parham, Bland, Post)
Therapy in Latinos- (Arendondo)
Therapy in Native Americans- The use of Ritual in therapy (Gone)
Case Conferences incorporating the DSM-IV-TR OCF

Year Four

Gender and Sexuality
Gender identity in development- watch and discuss excerpts from BBC Documentary,"7 & Up."
Erotic transference and counter-transference- watch and discuss vignette from HBO series, "In Treatment."
Female and male sexual dysfunction
Paraphilias
The effect of psychotherapist gender on therapeutic alliance
Gender Identity and Transgender health and mental health
Perimenopause
Sexual side effects of psychotropic medications
Advanced Cultural Psychiatry- Each senior resident presents a case incorporating the DSM-IV-TR OCF with a cultural consultant present to facilitate discussion (Lewis-Fernandez and Diaz, Chung and Lin, McGoldrick, Giordano and Garcia-Preto)