

What do I need to cover?

# Introduction Slides

AACAP Cultural Competency  
Curriculum

# Overarching 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

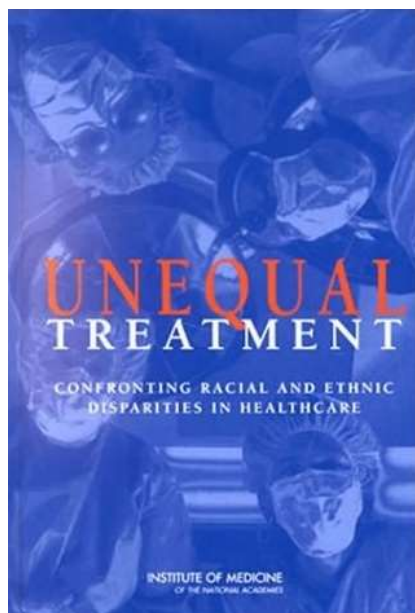
- **Basic:** The minimum level of cultural competency that a fellow should have upon completion of child and adolescent psychiatry training.
- **Intermediate:** The recommended level of cultural competency for a practitioner who is working in a community with a diverse patient population.
- **Advanced:** The level of cultural proficiency to which a practitioner can aspire as a result of experience and scholarship

# MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY

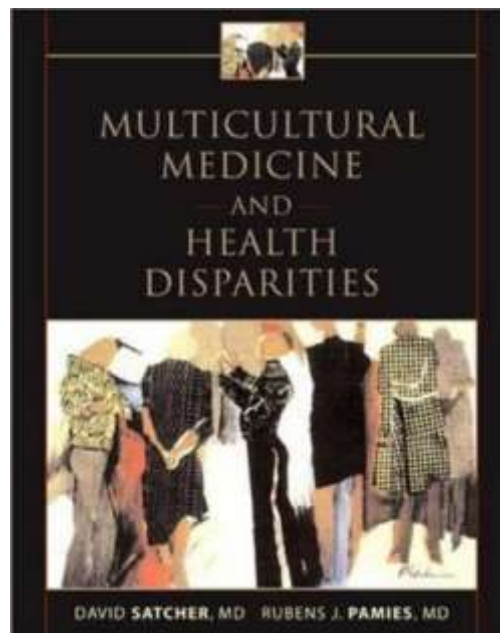
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A SUPPLEMENT TO  
MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL

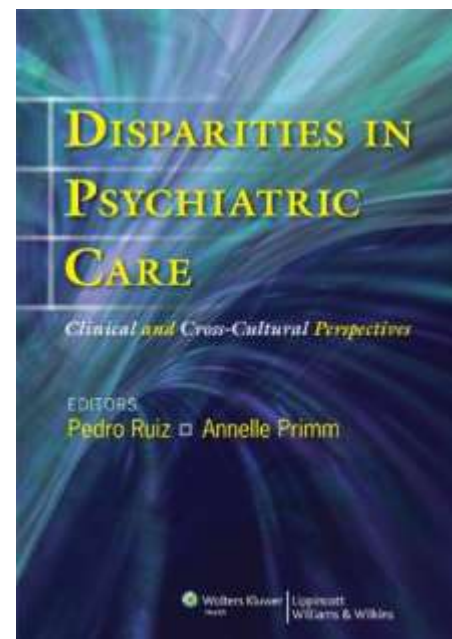
2001



2002

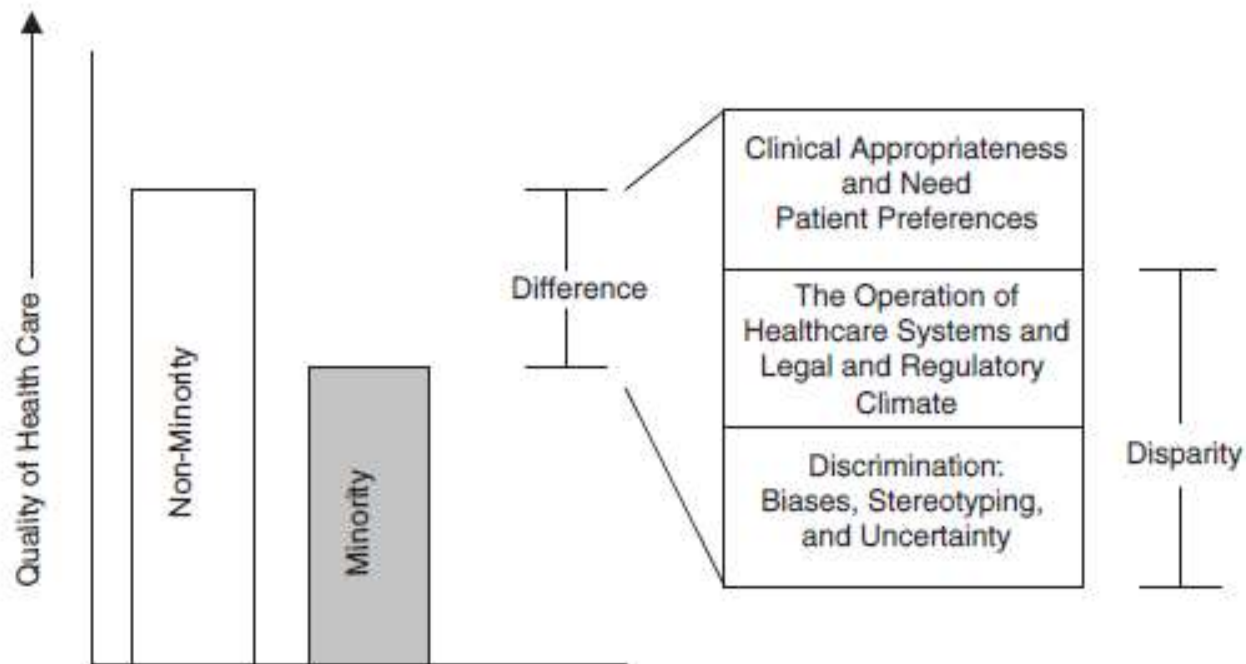


2005



2010

# Health Differences



**FIGURE S-1** Differences, disparities, and discrimination: Populations with equal access to healthcare. SOURCE: Gomes and McGuire, 2001.

# Patient Centered care

- The person at the focus of planning, and those who love the person, are the primary authorities on the person's life direction. The essential questions are
  - *Who is this person?*
  - *What community opportunities will enable this person to pursue his or her interests in a positive way?*

-O'Brien & Lovett, 1992

# Integration of Psychiatry/Behavioral Health in Primary Care

- Each patient has an ongoing relationship with a personal physician
- The personal physician
  - leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients
  - Is responsible for providing all of the patient's health care needs or appropriately arranging care with other qualified professionals
- Care is coordinated and/or integrated across all elements of the healthcare system
- Quality and safety are hallmarks
- Enhanced access to care is available



# Patient Centered Care

- Understanding Cultural Differences in each patient/family is important
  - At the biological level: People of **Mediterranean** heritage and Glucose-6-phosphate dehydrogenase deficiency (G6PD)
  - At the psychological level: Importance of co-sleeping vs. independent sleeping for infants and children in different families
  - At the community level: Awareness of Historical & Geographic differences in people of Irish Heritage residing in “Irish enclaves”

# IOM Findings

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

# Patient Centered Care

- Includes recognition of the individual patients unique heritage within understanding health and illness issues across populations
- Includes recognition of the impact of health differences in individuals
- Includes recognition of the impact of health disparities on individuals

**Race:** a sociological construct that is used to identify groupings that are presumably biologically and genetically determined. The concept of race has typically defined by anthropologists or sociologists, not by the individual.

*-Mental Health, Race & Ethnicity*

**Ethnicity:** a common heritage shared by a particular group. Heritage includes similar history, language, rituals and preferences for music and foods. Historical experiences are...pivotal to understanding ethnic identity and current health status

*-Mental Health, Race & Ethnicity*

**Ethnic or Cultural Identity:** That part of the individual's self-concept which derives from knowledge of membership in a social group or groups combined with the value and emotional significance attached to that membership.

**Ethnocentrism:** the tendency to judge all other cultural groups by the standards of one's own, with the assumption that one's own standards are correct and others are not.

**Minority group:** a group who because of their ethnicity, nationality, religion, class, physical or cultural characteristics are singled out from others for differential and unequal treatment

**Acculturation:** the process by which people from an ethnocultural minority adjust to and adopt the behavior of the dominant norm.

**Assimilation:** the process by which a minority ethnic group loses its distinctiveness.

**Multiculturalism:** the preservation of different cultures or cultural identities within a unified society, such as a state or nation.

*Dictionary.com*

**First generation:** refers to immigrants who arrived in their new country during their adulthood

**Second generation:** refers to the children of immigrants that were born in the new country

**Generation 1.5:** refers to children who were born in the country of origin and are now being raised in the new country



**Religion:** the more formal organized system of beliefs and religious practices

**Spirituality:** the individual's attempt within the inner self to construct meaning in life

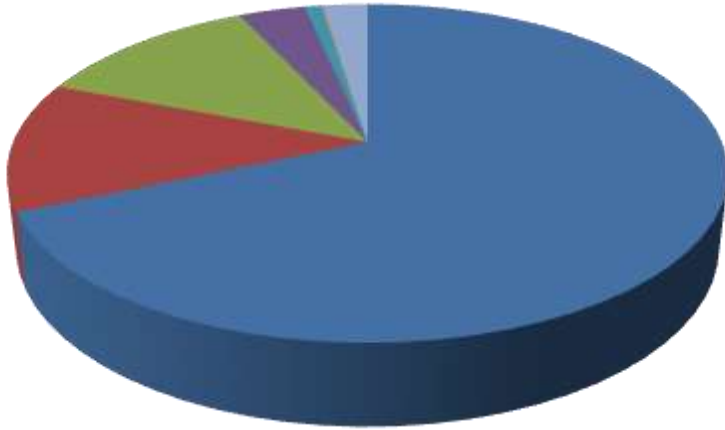
-Sexson, 2004

# “Official” racial and ethnic groups

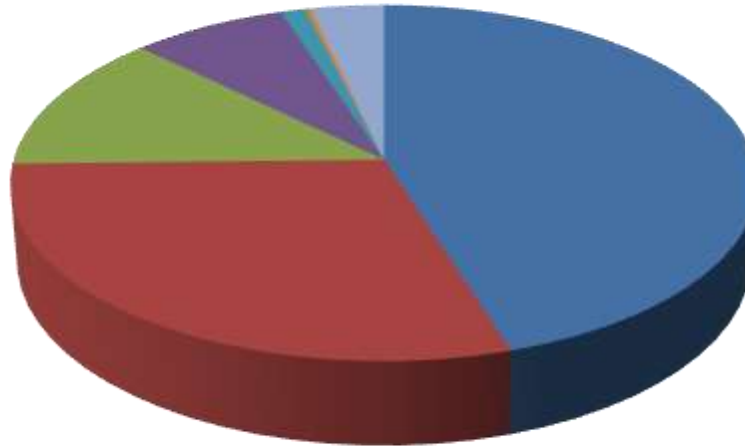
- One race
- Two or more races
- American Indian or Alaska Native
- Asian
- Black or African-American
- Native Hawaiian or Other Pacific Islander
- White
- Hispanic or Latino
- Not Hispanic or Latino

# U.S. Population by Race/Ethnicity Projections

2000



2050



- White, not Hispanic
- Hispanic or Latino
- Black or African American
- Asian
- American Indian and Alaska Native
- Native Hawaiian and other Pacific Islander
- Two or more races

# Importance of Diverse Children and Youth to the Future of the U.S.

- **Future citizens**

- Meeting developmental, educational health, and MH needs reduces marginalization, improves overall social/ community climate

- **Future family environments**

- Meeting developmental and MH needs minimizes future health, MH, and social welfare expenditures

- **Future workforce**

- Meeting health and educational needs maximizes potential for productivity and success
- Critical to U.S. economy in global competition (both education and bicultural and bilingual skills)

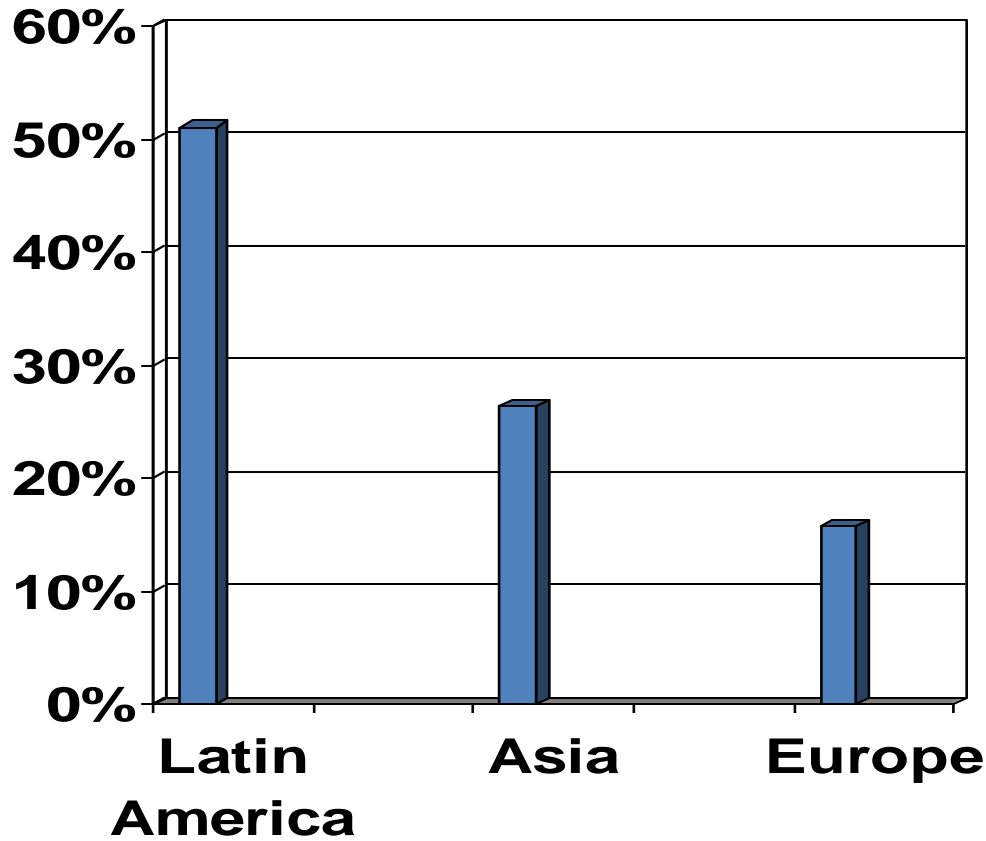
# Immigration and Refugees

- **U.S. accepts highest percentage of immigrants and refugees**
  - 1.2 million legal immigrants and refugees enter annually
  - 800,000 to 1.2 million undocumented immigrants enter annually, net increase of 400,000 to 700,000; total of 8 million estimated currently
  - Total number of immigrants (2000 to 2006): 7.6 million; 2.5 million in West, 2.4 million in South, 1.6 million in NE, 1.0 million Midwest
  - Continents of Origin: Africa- 881,000, Asia- 8.2 million, Latin America- 16.1 million, Europe- 4.9 million, North America- 830,000, 3.3 million under 18 years
  - **Total number of immigrants in U.S.: 40 million**
  - **3/4 of children of immigrants are US born**

# Immigrant Children and Children of Immigrants

- Immigrant children
  - 2.2 Million children in the U.S. are recent immigrants
  - By the year 2010 they will comprise 22% of school age children in the U.S.
- Children of Immigrants
  - 80 percent of children of immigrants are born in the U.S. and are US citizens
  - First and second generation immigrant children are the most rapidly growing segment of the U.S. child population (>30% of the U.S. school population)- Landale & Oropesa (1995)

# U.S. Immigrants by Place of Birth



**Latin America 53%**

**Asia 25%**

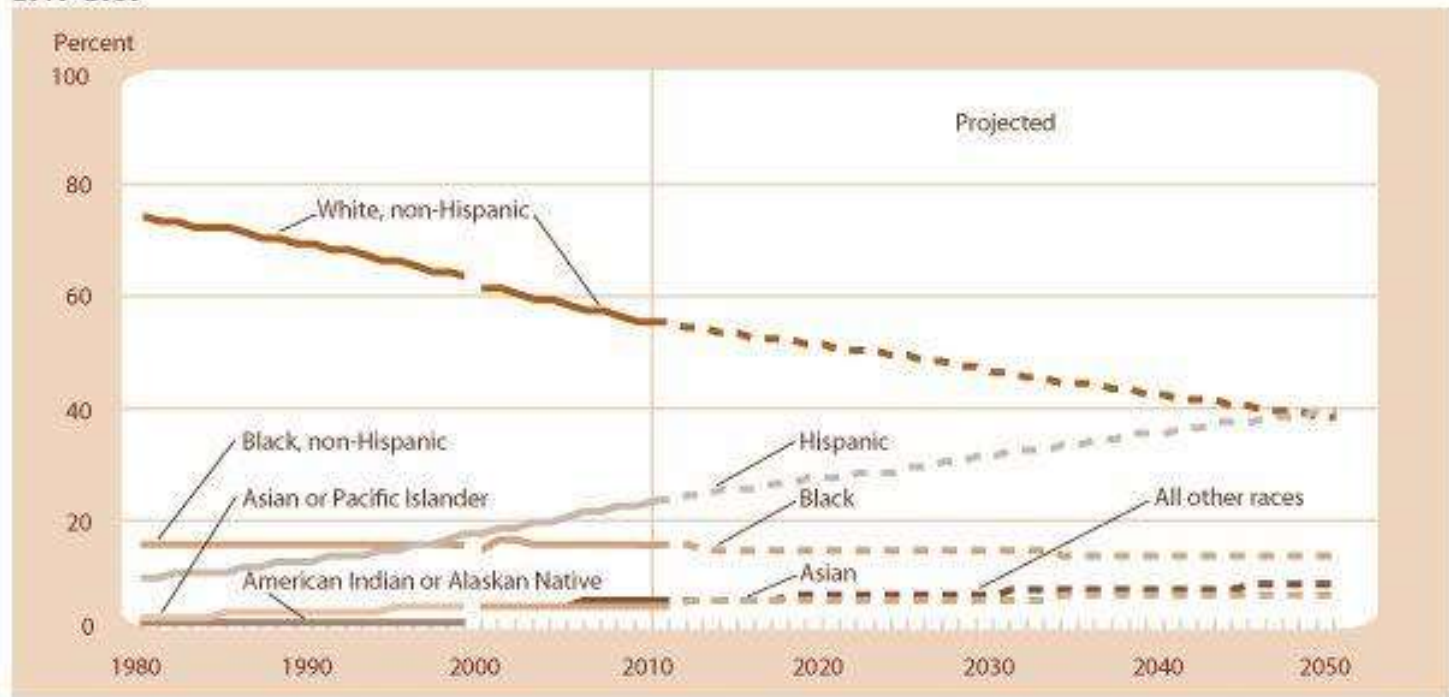
**Europe 13.7%**

**Africa 2.8%**

**Canada 2.7%**

U.S. Census 2003

FIGURE 1: PERCENTAGE OF U.S. CHILDREN AGES 0-17 BY RACE AND HISPANIC ORIGIN, 1980-2009 AND PROJECTED 2010-2050



SOURCE: U.S. Census Bureau, Population Estimates and Projections.



# 13 groups experience health disparities

- Racial/ethnic groups
  - African-Americans
  - Asian-Americans
  - Native Americans
  - Latinos
  - Immigrants
- Gender and Sexual
  - Women
  - Gay, lesbian, bisexual and transgender
- Special populations
  - The Appalachian poor
  - Those living with disabilities
  - The obese
  - The elderly
  - Prisoners
  - Certain religious groups

# Causes of Health Disparities

## Biological variables

Genetically mediated susceptibility

## Psychosocial-Cultural variables

Socioeconomic status

Awareness

Preferences

Beliefs about health

Beliefs about health care system

Social support

Self-efficacy

## Access-Related variables

Insurance

Geographic proximity to care

Temporal access (wait times)

Transportation

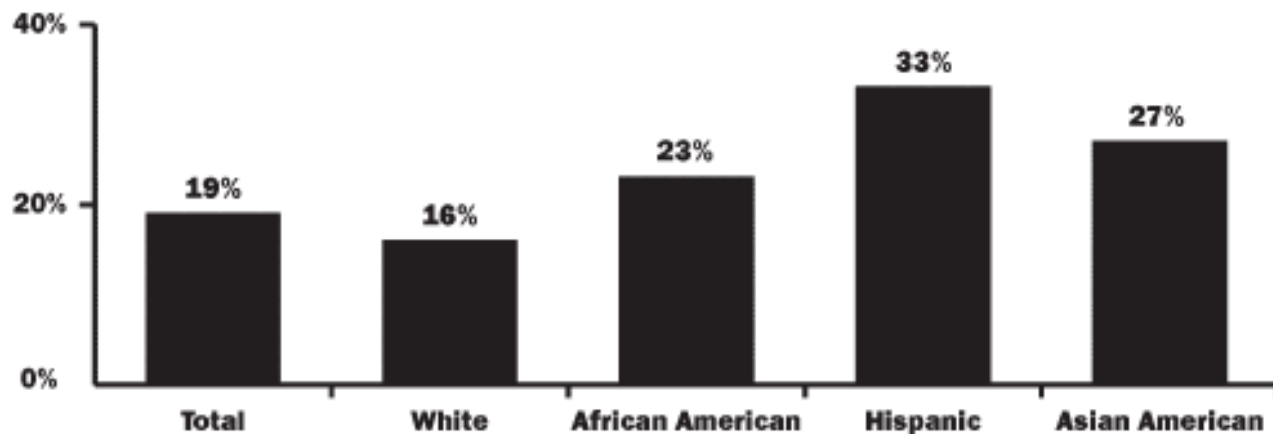
## Physician-health system variables

Treatment disparities

Cultural incompetence and insensitivity

## Minorities Face Greater Difficulty in Communicating with Physicians

Percent of adults with one or more communication problems\*



Base: Adults with a health care visit in the past two years.

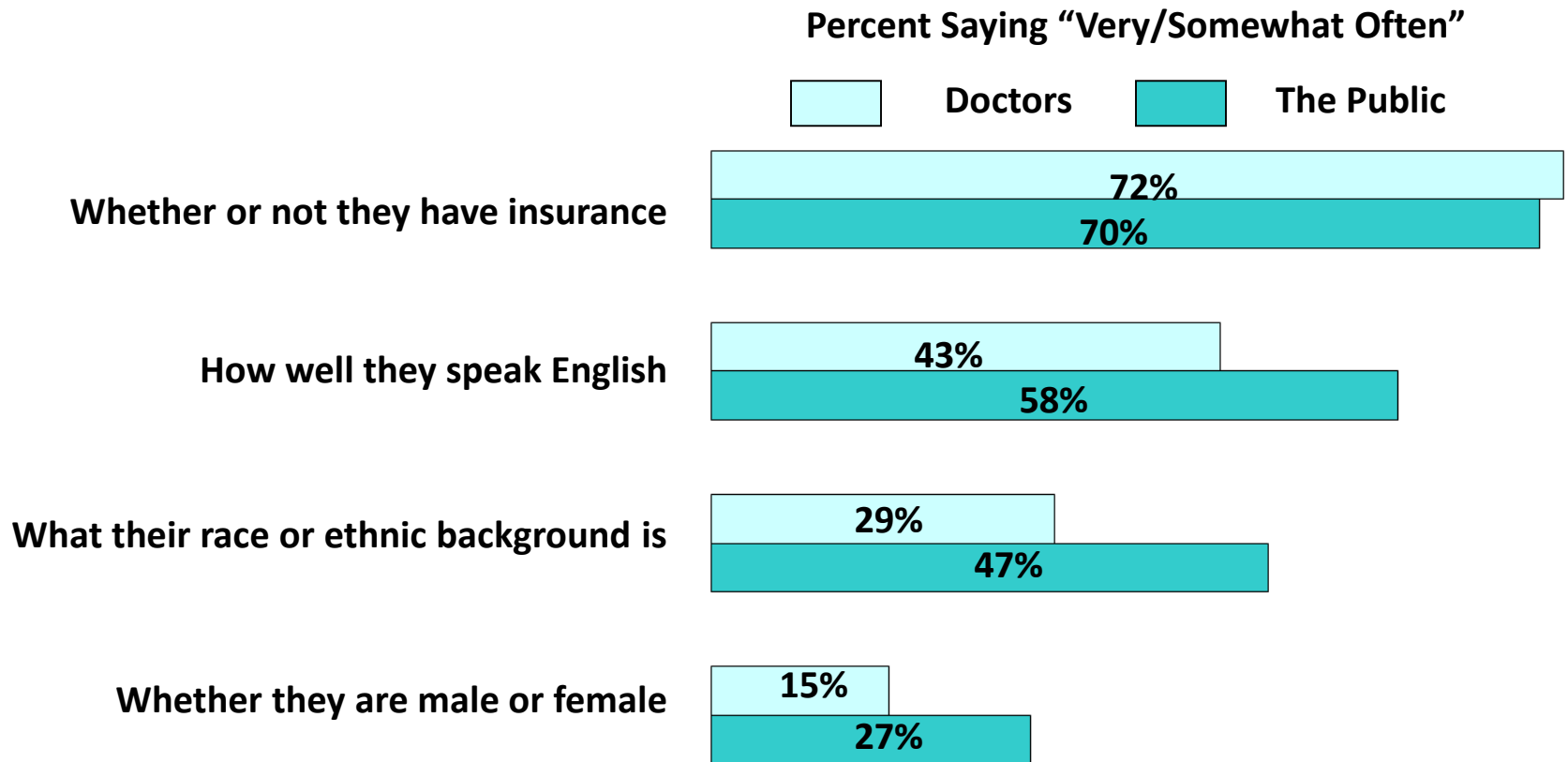
\* Problems include understanding doctor, feeling doctor listened, had questions but did not ask.

Source: The Commonwealth Fund 2001 Health Care Quality Survey.

Figure 22

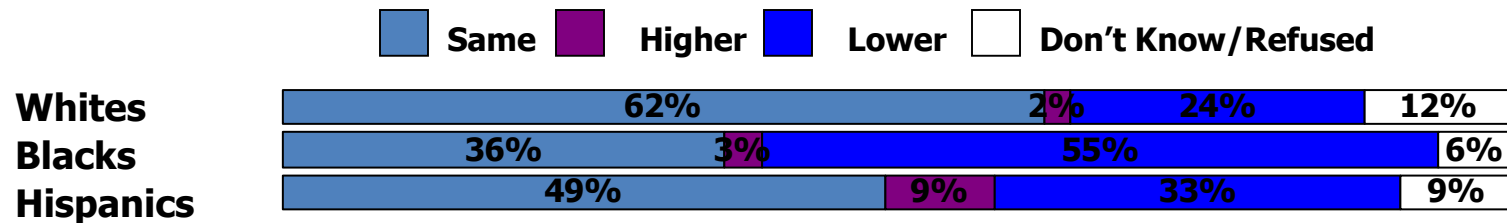
# Perceptions of Disparities in Health Care

Generally speaking, how often do you think our health care system treats people unfairly based on...

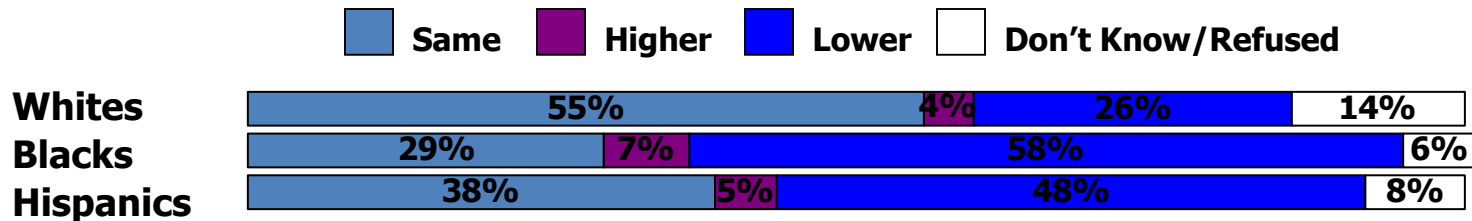


# Perceptions of Disparities in Health Care

When going to a doctor or health clinic for health care services, do you think most African Americans receive the same quality of health care as whites, higher quality of care or lower quality of health care as most whites?

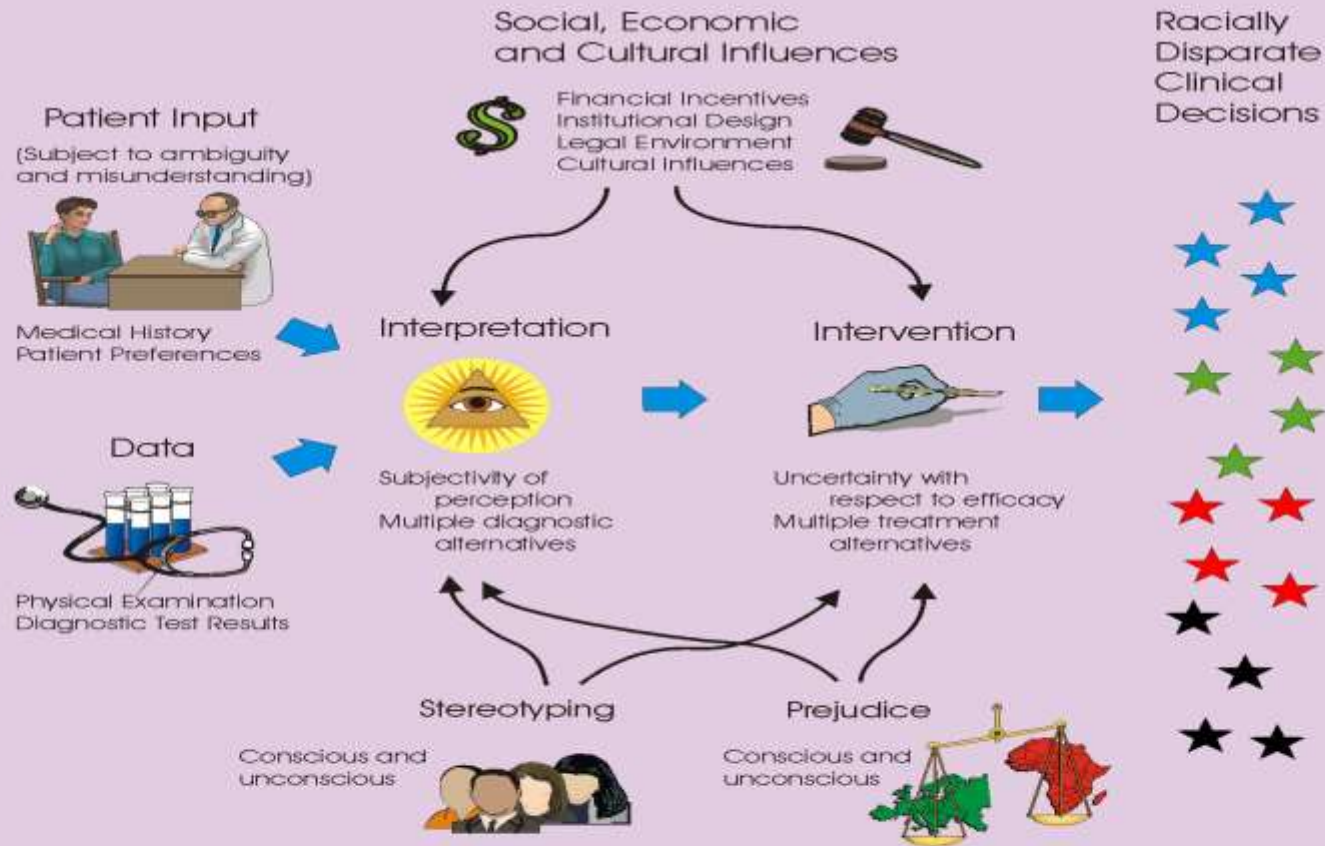


When going to a doctor or health clinic for health care services, do you think most Latinos receive the same quality of health care as whites, higher quality of care or lower quality of health care as most whites?



# Clinical Discretion

As exercised by clinical caretakers,  
gatekeeper physicians, and  
Managed Care Organization UM's



# Healthcare Disparities

- = Differences in quality of healthcare not due to patient preferences or clinical characteristics.
  - i.e., not related to
    - Access-related factors
    - Clinical needs
    - Preferences
    - Appropriateness of interventions
- Diagnostic and treatment decisions are influenced by patient's race/ethnicity
- Persist despite controlling of income and access to insurance

# Potential Sources of Disparities in Care

- Health systems-level factors – financing, structure of care; cultural and linguistic barriers
- Patient-level factors – including patient preferences, refusal of treatment, poor adherence, biological differences
- Disparities arising from the clinical encounter



# IOM Recommendations, 2002

- Promote consistency and equity of care through the use of "evidence-based" guidelines
- Produce more minority health care providers
  - These individuals are more likely to serve in minority and medically underserved communities
- Make more interpreters available in clinics and hospitals
  - to overcome language barriers that may affect quality
- Increase awareness about disparities among the general public, health care providers, insurance companies, and policy-makers.
- Cross Cultural Education of health care providers
  - Knowledge (learning about various cultures)
  - Skills (learning to work with people from different cultures)
  - Attitudes (cultural sensitivity awareness approach to the practice of medicine)

# Culture

The integrated pattern of human behavior that includes thought, speech and action....the customary beliefs, social norms and material traits of a racial, religious, or social group; the shared values, norms tradition, customs, arts, history, folklore, and institutions of a group of people.

Webster's Collegiate; Kim

# What does Culture do?

- Shapes behavior
- Categorizes perceptions
- Gives names to selected aspects of experience
- Is widely shared by members of a particular society or social group
- Is an orientational framework to coordinate and sanction behavior

# The Basis of Cross-Cultural

- Immigrant to U.S./Descendant
- Raised in U.S. as member of a devalued group
- Regional differences
- Intra-group differences
- Gender
- Sexual orientation
- Hearing
  
- Occupation (*i.e.* medical v. mental health)

# Components of Culture

Objective: easily seen,  
understood and accepted  
by other cultures

- clothing
- food
- artifacts

Subjective: less easily  
understood; provide bases  
for misunderstanding


- values
- ideals
- attitudes
- roles
- norms

# Cultural competence

A set of congruent behaviors, attitudes, practices and policies that come together in a system or agency, or among professionals, and enable that system or agency, or those professionals, to work effectively in cross-cultural situations

Cross, et al (1989)

# The Cultural Competence Continuum

- 
- **Cultural proficiency** – *differences are valued and seen as strengths. Continual efforts to augment knowledge and improve practices. The most advanced stage.*
  - **Cultural competence** – *acceptance and respect for differences. Commitment to incorporate new knowledge to better meet the changing needs of minority populations. An advanced stage.*
  - **Cultural pre-competence** – *recognition of limitations of services and staffing with effort to improve. There may be tokenism.*
  - **Cultural blindness** – *intended philosophy of being unbiased; embracing idea of “we are all the same.” Race and culture are not considered, and there is no truly individual approach to treatment and treatment planning.*
  - **Cultural incapacity** – *a lack of capacity to help children and families of color. No conscious intent to be culturally destructive, but practices may be discriminatory or paternalistic*

# Cultural Competence in Healthcare

- **Cultural awareness** is defined as the process of conducting a self-examination of one's own biases towards other cultures and the in-depth exploration of one's cultural and professional background. Cultural awareness also involves being aware of the existence of documented racism and other "isms" in healthcare delivery.
- **Cultural knowledge** is defined as the process in which the healthcare professional seeks and obtains a sound educational base about culturally diverse groups. In acquiring this knowledge, healthcare professionals must focus on the integration of three specific issues: health-related beliefs practices and cultural values; disease incidence and prevalence (Lavizzo-Mourey, 1996).
- **Cultural skill** is the ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conducting a culturally-based physical assessment.
- **Cultural encounters** is the process which encourages the healthcare professional to directly engage in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping.
- **Cultural desire** is the motivation of the healthcare professional to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful and seeking cultural encounters; not the "have to." Cultural encounters is the pivotal construct of cultural competence that provides the energy source and foundation for one's journey towards cultural competence. (Josepha Campinha-Bacote 1991)



# Conceptual Models of Cultural Competence

- CRASH- based on core principles of cultural competency
- LEARN- underlies more specific interview techniques
- CLEFS – perspectives from which to gather information from the patient

# CRASH

- Consider **C**ulture
- Show **R**espect
- Assess/**A**ffirm Differences
- Show **S**ensitivity and Self-Awareness
- Do it all with **H**umility

# LEARN

- Listen with sympathy and understanding
- Explain your perception of the problem
- Acknowledge and discuss the differences and similarities
- Recommend treatment
- Negotiate treatment

# CLEFS

- Cultural
- Linguistic
- Environmental/educational
- Follow-up care
- Strengths

# Culture Bound Syndrome

A recurrent, locality-specific pattern of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category....generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations....some conditions and disorders have been conceptualized as culture-bound syndromes specific to industrialized culture (e.g., anorexia nervosa, dissociative identity disorder), given their apparent rarity or absence in other cultures....all industrialized societies include distinctive subcultures and widely diverse immigrant groups who may present with culture-bound syndromes.

# Culture bound syndromes

- Amok
- Ataque de nervios
- Bilis and colera (aka muina)
- Boufee delirante
- Brain fag
- Dhat
- Falling- out or blacking out
- Ghost sickness
- Hwa-byung
- Koro
- Latah
- Locura
- Mal de ojo
- Nervios
- Pibloktoq
- Qi-gong psychotic reaction
- rootwork
- Sangue dormido
- Shenjing shuairuo
- Shen-k'uei or shenkui
- Shin-byung
- Spell
- Susto
- Taijin kyofusho
- Zar

# The Cultural Formulation

- Cultural identity of the individual
- Cultural explanations of the individual's illness
- cultural factors related to psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and the clinician
- Overall cultural assessment for diagnosis and care

# Cultural identity of the individual

- What are the individual's ethnic or cultural reference groups?
- For immigrants and ethnic minorities note separately the degree of involvement with both the culture of origin and the host culture, where applicable.
- Note language abilities, use and preference, including multilingualism



# Cultural explanations of the individual's illness

- Predominant idioms of distress through which need for social support are communicated – “nerves, spirits, somatic complaints, inexplicable misfortunes”
- Meaning and perceived severity of the symptoms in relation to norms of the cultural reference group
- Any local illness category used by the family and community to identify the condition
- Perceived causes or explanatory models used to explain the illness
- Current preferences for and past experiences with professional and popular sources of care

# Cultural factors related to psychosocial environment and levels of functioning

- Culturally relevant interpretations of social stressors
- Available social supports
- Levels of functioning
- Level of disability
- Stresses in the local social environment
- Role of religion and kin networks in providing instrumental and informational support

## Cultural elements of the relationship between the individual and the clinician

- Differences in culture and social status between the individual and the clinician and problems that these may cause
- Difficulty in communicating in the individual's first language
- Difficulty eliciting symptoms or understanding their cultural significance
- Difficulty in negotiating an appropriate relationship or level of intimacy
- Difficulty in determining if a behavior is normative or pathological

Overall cultural assessment for diagnosis and care

- How cultural considerations specifically influence comprehensive diagnosis and care

# The AACAP Cultural Competency Curriculum

- **GOALS**

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- **LEVELS OF COMPETENCY**

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# Meyers : Challenges in Providing a culturally competent healthcare system

Meyers analysis:

1. Clinical – differences amongst people of different racial and ethnic background
2. Communication – differences in style, method and meaning in communications even where the dominant language is being used well
3. Ethics – different belief systems will challenge firmly held western beliefs inculcated through years of professional development
4. Trust/respect – different levels of trust in where individuals have come from countries where authority figures have misused their positions. Respect in that some cultures will so respect a clinical authority figures that they will agree with the clinician and seek to provide 'acceptable' answers.

5.  
*Meyer CR. Medicine's melting pot. Minn Med 1996;79(5):5*