The Cultural Sensibility Model: A Process-Oriented Approach for Children and Adolescents

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• Cultural sensibility model • Psychiatry • Adolescents
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A BRIEF HISTORY OF CULTURAL PARADIGMS IN PSYCHIATRY

The history of the inclusion of culture within child and adolescent psychiatry is a limited one, and until recently has not attracted particular attention. This history is in many regards a modification of the broader trends set in general psychiatry and pediatrics that child and adolescent psychiatry has tended to follow. It has only more recently established itself as a specialty within its own right. Reviewing this history briefly helps provide a background for the model that this article proposes, and also highlights potential directions for future research and practice in child and adolescent psychiatry.

The First Moment: Recognition of Cultural Difference

Research on culture as a domain within medicine and psychiatry came into focus after World War II. Although the earlier psychoanalytic era often paid attention to aspects of culture within individual cases, the recognition of the multiple facets and complexity of culture can be most clearly linked to the rise of the disciplines of sociology and anthropology in the post-war era. This period was marked by a large number of United States soldiers who had fought across the globe, from Europe to Africa and the Pacific

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Islands. These soldiers returned to the United States and took advantage of the GI Bill to obtain access to higher education in the 1950s and 1960s. The modern faculties in the social sciences became led partly by professors who came through these pathways of education.

Among the many areas of interest to social scientists of this era were the cultural experiences of health and illness. It was during this post war era that the interdisciplinary behavioral science research and teaching programs established by the U.S. National Institute of Mental Health had a major impact on the social sciences. Harvard's Department of Social Relations, an interdisciplinary program led by the distinguished sociologist Talcott Parsons, brought together doctoral students such as Robert K. Merton, Clifford Geertz, Harold Garfinkel, and Renée C. Fox; scholars who would later change the fields of anthropology and sociology. Parsons himself was influenced by the work of Sigmund Freud, but extended his scholarship beyond psychopathology to seek structural models that would explain various aspects of the social system.

In the United States, these broader trends in the social sciences came to have their most significant impact on medical education through the publication of two key works in the late 1950s and early 1960s. The first was *The Student Physician*, edited by Robert K. Merton[1] in 1957, and *Boys in White*, by Howard Becker[2] in 1961. Both of these books showed that social factors not only were a part of the medical education process but also profoundly shaped the nature and attitudes of the students who were training to become physicians. These works linked to a broader reformist movement within medical education that sought to bring the social sciences to bear on the study of health and illness as a way to address factors that seemed to impact health care, and also as a means to train doctors to be more humane and empathic in their approach to care.

Notably in the field of psychology, Mary Ainsworth[3] published her studies of Ugandan childrearing practices in 1967. The volume was published several years after she completed her studies, but it shows a growing interest in trying to ascertain universal phenomena and patterns of child development. Ainsworth studied under John Bowlby[4–6] and was clearly influenced by his thinking and the conceptualization of attachment as a central point of childhood development. Both Bowlby and Ainsworth were attentive to the social environment but did not necessarily focus on culture as a key factor. Their studies sought to define general patterns of attachment and childhood development, and the research that they undertook beyond the Euro-American context was framed by this approach.

The Second Moment: Cultural Psychiatry Emerges

Despite this attention to social and cultural elements, very little of the research from this era focused on children or adolescents. Primarily in the 1970s and 1980s in the United States, a corpus of research began to emerge that examined ethnic differences of psychiatric illnesses for children and adolescents. Much of this research was driven by a small number of individuals in child psychiatric clinics who focused their efforts on the experiences of minority youth and families.

Jeanne Spurlock, for example, served as the chair of psychiatry at Meharry Medical College in the early 1970s, and thereafter moved to positions at the National Institute of Mental Health and the American Psychiatric Association in the 1980s. From these locations, she forwarded an agenda that illuminated the different experiences of ethnic minority youth, particularly African American children and adolescents.[7] In parallel, in the 1980s Hector Bird launched a series of studies, initially psychoanalytically focused and then epidemiologically, that examined the experiences of Hispanic and Puerto

Rican youth and the differential presentation of psychiatric disorders and their particular cultural manifestations.[8,9] Other scholars[10–17] could easily be cited to show this trend further, but space limitations do not allow a full explication on this period.

Family therapy, which is a widely used modality of intervention in child psychiatry, also began examining the meaning of culture for families and its impact on their development and functioning. During this period, the field of child and adolescent psychiatry also became more international, and studies from parts of the world other than Europe and North America were added to the literature. Child psychiatrists from non-European and American backgrounds clearly also began training in these contexts and added different perspectives to the clinical experience.

The Third Moment: Cultural Competence in Medical Education

During the 1980s and 1990s, the American Association of Medical Colleges (AAMC), and accreditation bodies in the both the United States and United Kingdom began pushing to include more teaching about ethnic and cultural issues as they pertain to medical education into the curricula of all educational institutions.[18] Much of this was driven by the growing recognition that health disparities existed between different groups in society and that ethnicity, culture, gender, and socioeconomic status may all be relevant variables. This model posited that the practice of medicine was influenced by these factors and that disparities were recognized as having roots in the racial biases of individual practitioners and broader structural, economic, and social trends that entrench patterns of behavior and risk that differentially affect minority populations.

In the United States, the cultural competence model became the accepted mode for teaching about these topics. The general pattern of these courses focused on first defining the fact that culture (usually used interchangeably with ethnicity and race, and seen as being the indicator of culture) has an impact on practice and that health disparities exist, and then presenting a series of lectures or units that covered the health attitudes, beliefs, or experiences of various minority groups. Culture, in this way, was presented as being primarily defined by ethnicity and little attention seems to have been paid to the complex interplay between the different factors. Groups were also presented as relatively homogenous. Typically, the groups would include the dominant minorities in the United States, such as African Americans, Latino/as, Asian Americans, and Native Americans. Many courses would recruit lecturers from specific backgrounds to teach on each of these groups, and would sometimes draw on local sociologists or anthropologists to provide the necessary teaching. In less-ideal situations, clinicians would do their best to cover this material by drawing on the limited teaching resources available. The cultural competence model emphasized a notion that clinicians and trainees need to develop expertise in particular cultures to be effective providers.

In 1994, the Fourth Revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) included as Appendix I an "Outline for Cultural Formulation" (the Outline) for the first time.[19] This shift was prompted by the actions of many advocates for ethnic and minority issues who had pushed for greater inclusion of these concepts in the DSM. The placement of the Outline in the appendix was seen as recognition of the importance of these topics, whereas the relegation of it to the end of the DSM seemed to minimize some of its potential impact. The Outline, along with the accompanying "Glossary of Culture-Bound Syndromes," are bridges from the expertise model to a more process-oriented approach. It recognizes the need to create a space for understanding the individual's cultural experience of health and illness, and does so in ways that are highly pragmatic. The inclusion of the concept of

culture-bound syndromes creates a differentiation between a mainstream experience of psychiatric illness and other or external cultural experiences.

In many respects, the Outline creates the potential for a process-oriented framework. In practice, the current trends in medical education tend to focus on teaching content about culture based on a single narrative or broad generalizations. Current research in the social sciences has, in some fundamental ways, abandoned the concept of master narratives with the postcolonial and postmodern turn.[20–22] For example, the limitations imposed by creating a list of culture-bound syndromes are many. Such a list is necessarily incomplete and also represents a fixed notion of these experiences. The need to generalize for expediency of teaching faces a challenge because of a lack of specificity and inclusivity of the vast range of cultures present in the world.

The final major challenge facing the Outline is that it is not written with a focus on child and adolescent psychiatry. This fact is especially problematic because a distinct lack of acknowledgment of developmental process exists within the DSM as a whole. Although the experts who developed the outline were clearly aware of the differential nature of family structures and influences on the psychiatric experience of illness, the overall structure of the DSM necessitates a more individualistic and targeted framework that is reflected in the Outline. Francis Lu, one of the pioneers of the cultural formulation, and others attempt to address this gap elsewhere in this issue, and readers are encouraged to look for insights into their approach as complement to the model proposed herein. Although this article does not wish to classify having expertise as a problem per se, in the current multiethnic, increasingly diverse world, having a dynamic and process-oriented approach seems to make sense, and is likely necessary given the simultaneously globalizing and differentiating local cultures.

The model proposed by Dogra[23] examined the extremes of potential cultural education models. The reality is that most programs likely incorporate aspects of both models. However, unless educators are explicit about their philosophic base, the models developed are unlikely to be coherent. It is also important to stress context: the cultural competence type models arose at a particular time when ideas were relatively new and less debated than currently. The authors recognize the importance of the cultural expertise type programs in having created the groundwork for other models to be developed, and that at the time they were developed they challenged the status quo and identified that culture was an important factor to consider when looking at health matters.

THE NEXT MOMENT: THE CULTURAL SENSIBILITY MODEL

The authors propose that the field of child and adolescent psychiatry needs to move to a more fully developed process-oriented approach to culture and diversity issues. This framework must be designed to guide the practitioner into discovering and learning about the child, adolescent, and family's culture. It also must recognize that developmentally, adolescents and teens may begin to define their own self-definition of culture as being different from that of their family of origin.

This framework also must recognize that an individual's, family's, and society's culture is not fixed and is a dynamic process that changes over time. Individuals likely change faster than families, who in turn change faster than society. Nevertheless, inferring that culture is a constant would be a mistake, and practitioners may need to revisit cultural elements repeatedly over the course of a therapeutic relationship.

Development of the Cultural Sensibility Model

The cultural sensibility model was developed by one of the authors as part of research that investigated the learning and teaching of cultural diversity to medical students in the United Kingdom.[23] It arose because at that time few clear educational models or processes existed in the field for educators to follow. The model has since been applied in training in several contexts. The authors also suggest that the framework can be used without necessarily arriving at the same programs they might devise.

Educational Models: Ideal Types of "Cultural Expertise" and "Cultural Sensibility"

Using Weber's construct of ideal types,[24] Dogra[25] compared several characteristics of the concepts of *cultural expertise* and *cultural sensibility*. These characteristics are grouped into four major areas of course development:

1. Educational philosophy and policy
2. Educational process
3. Educational content
4. Educational and clinical outcomes.

Educational philosophy and policy usually inform all stages of course development and also affect the educational process, educational content, and outcomes. When discussing the educational process, the way that the educational philosophy is translated into practice is an important guiding principle. The question is how the values and ideologies of the course directors are used to develop the course. Some course designers may, of course, not recognize that their underlying beliefs about the merits or disadvantages of certain approaches influence their choices. In considering educational content, the very nature of the material is under review. This stage involves identifying the key areas that the teaching will emphasize and whether the programs will focus on the attainment of knowledge, skills, or attitudinal outcomes. Assessment is often perceived to be the major educational outcome measure, but there will be other outcomes, with some more explicit than others.

Cultural Expertise and Cultural Sensibility

A dictionary definition of *expertise*[26] is expert skill, knowledge, or judgment, with *expert* being defined as having special skill at a task or knowledge in a subject. A view exists that through learning knowledge about other cultures, one can develop cultural expertise and that much of this knowledge can be learned through didactic teaching. *Cultural expertise* is having facts about other cultures. The concept of cultural expertise encompasses the well-established model of cultural competence.

Cultural sensibility is proposed to broaden the concept of cultural sensitivity, which generally has been a tentative alternative to the idea of cultural expertise. A dictionary definition[26] of *sensibility* is an openness to emotional impressions, susceptibility, and sensitiveness. It relates to a person's moral, emotional, or aesthetic ideas or standards. Cultural sensitivity is not the same as cultural sensibility. Cultural sensitivity is the quality or degree of being sensitive, which is more limited than sensibility and does not take into account the interactional nature of sensibility. If one is open to the outside, one might reflect and change because of that experience; this is not necessarily the case with sensitivity.

The approach of cultural sensibility arose from the author Nisha Dogra's work in cultural diversity and medical education, and an experience that the cultural expertise model potentially limits the benefits of cultural diversity teaching.

The different underlying philosophies of the cultural expertise and cultural sensibility models result in differing educational processes, contents, and assessments (**Table 1**). Using the cultural expertise model, the following outcomes in each of the learning domains might be used:

Knowledge: history and culture of country of origin; pertinent psychosocial stressors, family life, and intergenerational issues; culturally acceptable behaviors versus psychopathology; role of religion; cultural beliefs about causes and treatments of disease; and differences in disease prevalence and response to medicine and other treatments.

Skills: interview and assess patients in the target language (or via translator); communicate with sensitivity to cross-cultural issues; avoid under-/overdiagnosing disease states; understand the patient's perspective; formulate culturally sensitive treatment plans; effectively use community resources; and act as a role model and advocate for bilingual/bicultural staff and patients.

Attitudes: as evidence of understanding, acknowledge the degree of difference between patient and physician; to demonstrate empathy, recall the patient's history of suffering; allow for a shift away from the Western view of time and immediacy; respect the importance of culture as a determinant of health, the existence of other world views regarding health and illness, the adaptability and survival skills of patients, the influence of religious beliefs on health, and the role of bilingual/bicultural staff; and show humor by having the ability to laugh with oneself and others.[27]

By comparison, possible learning outcomes for using the cultural sensibility model might be:

Knowledge: the focus of cultural sensibility is not strictly knowledge about groups. Students are expected to be aware of broad psychosocial issues that can affect the way individuals perceive health and access health services. A need exists to have knowledge of the contexts in which information is presented or received.

Skills: the greater focus on this model is the acquisition of a method for acknowledging difference, and working with it in a constructive and positive way. Difference between the doctor and patient is potentially present in all encounters and not just those in which ethnicity differs.

Attitude: the focus is on self-reflection and awareness; the interaction between two individuals, which generates effective, shared understanding and dialog. The dialog has the potential to change either, both, or neither of the participants. It is built on a transformative learning approach.

The previous comparison focused on the conceptual differences between the two models at their purest. Cultural expertise models arose from the recognition that cultural influences impact on health care provision and use. The approach of cultural sensibility is presented as an evolution of the cultural expertise approach, which potentially limits the benefits of cultural diversity teaching. In an environment that demands increasingly evidence-based approaches, tighter teaching models may need to be developed that have clear conceptual frameworks and can evaluate more effectively whether the teaching meets its objectives. This concept is revisited later when the impact of educational programs is considered.

Why Use a Cultural Sensibility Approach?

The justification for any approach is ideally based on both best practices and firmest evidence. No major research has been published regarding the outcomes of any particular approach over another. Various programs have shown benefits, but little long-term follow-up has been conducted, and comparison is difficult across different programs because the material covered varies considerably. A description of the range of programs that have been used is beyond the scope of this article. Beach and colleagues[28] reviewed many cultural diversity education programs and concluded that cultural competence training shows promise as a strategy for improving the knowledge, skills, and attitudes of health professionals. The review from which the paper was generated is useful, because it identifies programs that are well described and may therefore be useful to other educators.

The cultural sensibility approach is advocated for the following reasons:

- As an educational model it is explicit about all stages of the educational process, from educational philosophy to learning outcomes.
- The position and perspectives of the authors are transparent.
- The meanings of key terms are described and the definition of *culture* that is used to show the model is justified.
- The model shows that everyone, and not just those from minority ethnic groups, have "culture."
- The approach supports the development of skills that can be attained through practice and self-reflection.
- It highlights that relationships are dynamic in their nature and that changes across one system may lead to changes in another connected system.

Hobgood and colleagues[29] describe different methods to teach cultural competency, and provide examples of each. Dogra[23,25] looked at the various programs described (with some of the examples those used by Hobgood and colleagues) and tried to ascertain which educational model they fit in with best. Most models tend to be a combination of cultural expertise and cultural sensibility. Methods such as portfolios, case studies, and cultural immersion can seem very appealing initially but may also encourage students to develop stereotypical representations based on "ethnicity" alone. The models may fail to acknowledge that individuals are more than just their ethnicity. For example, to learn about gay Hispanic men, would students immerse themselves in "gay" or "Hispanic" or "male" culture? In reality, the intersection of these groups is far more complex, and resists the notion that simply studying each specific culture can yield the necessary information to treat the individual at this intersection.

Another common approach is to focus on communication and give students useful checklists to attempt to understand the patient perspective, such as those developed by Berlin and Fowkes.[30] They recommended the LEARN model: *Listen* with sympathy and understanding to the patient's perception of the problem, *Explain* your perceptions, *Acknowledge* and discuss the differences and similarities, *Recommend* treatment and *Negotiate* treatment. Kleinman's questions,[31] which are a range of questions exploring the patients perspective on the causes of their problems and their hopes and expectations of treatment, can also be used.

The difficulty with the focus on communication is that students may fail to consider their own biases and prejudices that may influence how they can effectively apply these strategies. Communication is at the core of the clinical consultation, but so too is the impression patients and family gather of their doctors' genuineness and respect for them.

Table 1
Summary of comparison between the different educational components of cultural expertise and cultural sensibility

Item	Cultural Expertise	Cultural Sensibility
Educational philosophy		
Epistemology (ie, the theory of knowledge)	Knowledge exists independently	Knowledge is contextual to one's environment
Categorization of knowledge	Core competency is about categorizing groups of people and that these categories can be learned (ie, knowledge can be categorized)	Knowledge does not need to be categorized
Use of categorization	Categorization is helpful	Categorization may be unhelpful
Ontology (the nature of being)	Positivist (a view that one single empirically testable reality exists)	Social constructivist (a view that we live in a reality that is created by socially driven meanings and that this reality is framed by the standpoint of the observer)
Conception of reality	Objective reality to be revealed or discovered Structuralist Modern	No single objective reality to be discovered Nonstructuralist Postmodern
Analytical perspective	Reductionist	Holistic
Historical connection	Rooted in historical context of minority disadvantage and white domination	Steps outside of the historical context of race
Politics of institutions	Improve competence of providers and/or users to improve access to care/services	Proposes that competence, as a static concept, does not encompass the dynamic nature of clinical relationship
Relation to inequalities	Attempts to change and reduce health care inequalities	Acknowledges inequalities but as such does not directly attempt to change them
Role of teacher	Teacher sets the agenda	Teacher introduces the agenda
Role of learner	Primarily as receiver	Student contributes to the dialog and receives information
Conceptions of culture		
Conceptions of culture	Culture is an externally recognized characteristic Static One-dimensional Race/ethnicity emphasized Unitary	Culture is an internally constructed sense of self Dynamic/fluid Multidimensional Race is but one aspect Diverse/differentiated

Perception of individual's relationship to society		
Conception of difference	Generalizes the differences between individuals	Sensitive to differences
Identity formation	Individuals are shaped by their social world	Individuals construct and accomplish their own social world
Conception of individual identity	An individual is defined by their culture	An individual defines their culture
Individual's relationship with society (relationship of self with society)	In defining culture, relationship is between groups	In defining culture, relationship is between an individual and others
	Dialog about culture takes place between groups	Dialog about culture takes place between individuals
	Individuals remain as defined by their culture, irrespective of the context	Individuals bring their own meanings and histories to different contexts (ie, the meanings may change dependent on the context)
Educational process		
Learning process	Acquisition of knowledge	Acquisition of principles (method)
Learning outcomes	Command of body of information and facts	Command of mode of respectful questioning
Expression of learning goals	In terms of skill and competence	In terms of attitudes and self-reflection
Content	Certain Dichotomous Right or wrong	Acknowledge uncertainty Mostly gray areas Not always right or wrong
Cultural focus	Majority view of other cultures dominant Majority whites must consider needs of minorities	No focus on particular groups, all individuals must consider needs of others
Cybernetics theory	First order (ie, the teacher teaches the student)	Second order (ie, the student and teacher learn together)
Pedagogic approach	Didactic	Directed self-learning
Role of experts	There are those who are experts on understanding cultural perspectives of certain groups	No one individual has ownership of expertise of others with respect to identification of cultural belonging
Educational content		
Curriculum type (as relating to Bernstein, 1973)[43]	Collection type	Integrated type
Nature of content	Parochial Specific	Global Nonspecific

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Table 1
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Item	Cultural Expertise	Cultural Sensibility
Organization of content	To meet demands of local need	To maximize student self-learning
Curriculum	Fact acquisition to gain a body of knowledge	Self-reflection and self-awareness of students
Teaching focus	Groups (treats people as groups) More service-centered	Individuals (views individuals as potentially parts of different groups in different contexts) More patient-centered
Focus of content	Students learn about others	Students learn as much about themselves as about others
Outcomes		
What purpose does the assessment serve?	Demonstrates knowledge of other cultures	Demonstrates some understanding of self and ability to evaluate their own learning
Which methods are used?	Paper and pencil tests ranging from multiple- choice questions and short answers to long essays	Reflective journals, project work (usually experientially based)
Results of assessment	Norm-referenced (ie, students ranked against peers)	Not norm-referenced
Who leads the assessment process?	Teacher assessment	Student self-assessment
Measures to check outcomes	Checklists	Self-assessment
Outcome in clinical practice	Practical in that learner has facts about other cultures	Practical in that learner has a method of inquiry to be aware that others may have different perspectives More critical and self-reflective Greater capacity for dialog
Applicability	Learning can only be used for cultural issues	Learning can apply to any context in which differences exist between the doctor and patient, whether they are cultural-, gender-, or education-based
Patient centeredness	Doctor has position of expert	Doctor and patient are active partners in care
Definition of successful course	Students learn competence regarding other cultures, and bonus if students learn about themselves	Course is only successful if students learn about themselves, because this is necessary before they can relate to other perspectives

ADAPTING THE MODEL TO CHILD AND ADOLESCENT PSYCHIATRY

Psychiatry has been at the forefront of developing training in culture, because it has been long recognized that culture plays a part in how mental health is understood, how treatment of mental health problems are sought, and who is consulted about them (for example, transcultural psychiatry has been established for many years, as have journals such as *Transcultural Psychiatry, Culture, Psychiatry and Medicine* and, more recently, *The International Journal of Culture and Mental Health*, even while the understanding of culture has continued to develop). In the United States, the accrediting organizations for both undergraduate (Liaison Committee on Medical Education for medical school) and graduate medical education (Accreditation Council for Graduate Medical Education for residency and fellowship) have made this training mandatory across all medical specialties. In the United Kingdom, however, mental health is the only clinical specialty in which training in cultural issues is mandatory. Other specialties may then consider that these issues are not as relevant for them.

In the United States, psychiatry has strived to move away from its exclusive focus on psychoanalytic principles to become more biologic in focus and join other medical disciplines in having what is believed to be a rigorous and standardized approach to diagnosis and treatment. Although this move can be debated, the reality is that the "softer sciences" of anthropology and sociology were marginalized in the discipline just when cultural competence arose as a requirement from the medical education accreditation authorities. Furthermore, significant changes occurred over the past 20 years in the way culture is viewed, with essentialist perspectives being increasingly challenged. In trying to adapt any model to clinical context, it is useful to consider what implications diversity issues have on the practice of a particular medical specialty. In doing this, educators can identify the factors that may be specialty-specific.

Dogra and Karnik[32] argue that a cultural sensibility approach within the AAMC definitions places the practitioner in a position of learning about the unique cultural situation of a particular child and his or her family, allowing the assessment process to be used to gain information that will ensure any management plan incorporates the cultural perspective of the family, and thereby having the most potential acceptability to them.[33,34]

Clinicians must also identify their own biases about specific children and families. These assumptions constitute the "baggage" taken into the clinical or consultation context. Conscious awareness of bias is important not only because it may lead to suboptimal care toward those toward whom prejudice exists but also because overcompensation may occur from a sense of guilt. For example, if clinicians are uncomfortable dealing with a particular cultural subgroup but do not acknowledge this, they may be overly sympathetic and supportive in a context in which the more appropriate response may be to expect more responsibility from the young person or family. In training, this is often glossed over as "awareness" of the problem. However, the authors believe this approach must be more rigorous, and clinicians' assumptions must be challenged as routine practice.

The findings of Garland and colleagues[35] that adolescents, caregivers, and therapists have different expectations for outcomes of the consultation can also highlight how culture might influence who is allowed to express themselves at meetings. Family expectations may mean that the therapist is not supposed to give as much weight to the young person's perspective as to that of adults, or that the father's view may override the maternal perspective. All of these dynamics require careful negotiation and sensitivity, yet cannot be ignored. It is arguable that anyone working with patients and their families must be aware of these issues. However, effective child and adolescent psychiatry practice cannot be achieved without them.

The Cultural Sensibility Approach in Everyday Practice

The authors favor an approach that uses the clinical encounter as the beginning for the development of the cultural sensibility view. When engaging with their patients, they not only elicit important information about history and symptoms but also ask about elements of culture as these arise naturalistically in the encounter. The authors resist making assumptions about beliefs and instead tend to ask what the patients think about, how the symptoms began, what medicines mean, how the patients view psychiatry, and what the patients are hoping to achieve today. Superficially, these questions seem like standard open-ended clinical history questions, but when taking into consideration the culture of the individual and family, they take on a very different tone and focus.

Case Example

A 16-year-old woman with cystic fibrosis living in the San Francisco Bay Area was hospitalized because of disease exacerbation , and reported on several elements of her history and overall physical functioning. Her father was her only immediate family; her mother had died of a drug overdose several years earlier and her brother no longer lived in the household and had severed contact with the father, although he continued to keep in touch with the patient through phone calls. The patient herself used cannabis and alcohol, and smoked cigarettes regularly, causing regular flares of her cystic fibrosis. On interview, the child psychiatrist asked follow-up questions about her life, school, and home situation. It became apparent that although her father as a single parent was doing his best to provide for her, she spent large amounts of time without adult supervision. Her self-defined culture revolved around Facebook, her basketball-playing friends, and a series of unsupervised parties. The tobacco, drugs, and alcohol were elements of this culture and were partly the driving forces at the parties that she attended. This patient knew the calculus that she was engaged in: she was sacrificing her future health to have fun in the present. Her father's culture, in contrast, was framed by the blue-collar job he held as a truck driver and his constant efforts to make financial ends meet to support himself and his daughter. He recognized the destructive pattern that his daughter was on but felt powerless to prevent it, and they argued regularly.

The intervention in this case became one of reconciling the two cultures. The process began in eliciting the cultural perspectives. The reconciliation began by having the father understand his daughter's perspective that she was going to die despite whether she continued a clean-and-sober approach; that it was simply a matter of time. The father then decided to approach two of his daughter's friends and talk with them about their mutual partying and substance use. These friends knew about the patient's cystic fibrosis, but were unaware of the impact smoking had on her health. They cared deeply for their friend, and elected to change their patterns and try to get the patient to quit smoking. These friends also began to effect a change in their local cultural milieu by convincing many of their friends to start to have substance-free parties. Initially, the patient was upset about her father's interventions in her local world, but as her friends helped normalize the changes, she gradually came to accept them as a process of growing up and becoming more like an adult.

The cultural sensibility approach incorporates a developmental perspective through its very nature. It recognizes that culture is one of several elements, such as morality, spirituality, and personal beliefs, that evolve and emerge over time. Ward Goodenough[36] defined culture as "whatever it is one has to know or believe to operate in a manner acceptable to its members." For children, the members could be family,

friends, or other social circles. Adolescents may identify with (and even define themselves in) different cultures at different points in time and depending on whom they are interacting with at the moment. This behavior is particularly true for teens who want to keep their family from understanding the other cultures to which they ascribe. For example, a gay teen might ascribe to views of other gay teens he spends time with at school or in other settings, but if he has not yet "come out" to his parents, he may present himself in an entirely different cultural light when he is with his family.

The process approach takes time for therapists to develop in a relationship with the patient and family, and also allows for cultural understandings to dynamically change over the course of treatment. Providers who want to use this approach can begin with some of the questions in the Outline,[19] and then continue to process and investigate the deeper aspects of cultural experience that emerge during treatment. The authors believe that culture is at the very heart of the therapeutic alliance in child and adolescent psychiatry: from the family's views about medications to the experience of psychiatric symptoms and their meaning in the social world.

Developmentally, cultural understanding may change and shift rapidly. Generally, toddlers and school-aged children share most of their culture with their parents or guardians. At these ages, the understandings of culture may be expressed by the child neither as a set of understandings nor as an overall system. It is more likely to emerge as a series of individual elements. For example, the child might describe the type of foods that she likes and how her mother prepares particular dishes that are unique and different from the foods that her friends and their families eat. The school-aged child can certainly appreciate difference but may not have the broader context within which to place these differences.

As the child grows and enters the middle school–aged years, she will begin to formulate more of a system. She will then likely have developed particular opinions and thoughts about music, movies, popular culture, and style that she sees reflected around her. At this point, the (now) teen may begin the process of differentiating from the parent's or family's cultural view. At this stage, young adolescents begin to identify with increasingly specific peer groups, and these groups begin to influence teens' perception of their own selves and consequently their culture.

In middle to older adolescence, as with many other developmental milestones, youth begin to differentiate from their families. This developmental period is characterized by elements of resistance and self-discovery. Cultural self-identification is one aspect of this process. Youths may see their parents as having outmoded beliefs, and not truly understanding the world as they know it. First relationships, an increasing reliance on peers, and greater immersion in popular culture and media may lead to a higher likelihood of cultural differentiation.

All of these cultural developmental processes are themselves ensconced in larger cultural frames. For some youths, this process will move rapidly, with a high degree of differentiation from their families of origin, whereas others will move along this continuum slowly and only marginally differentiate themselves. Thus, in practice, the child and adolescent psychiatrist must be sensitive to the developmental stages of their patients to accurately gauge their culture and the degree of relationship to the family.

TEACHING THE MODEL TO STUDENTS AND TRAINEES

It is arguable that diversity issues should be addressed during basic medical undergraduate education (before residency or fellowship). During child and adolescent training, the skills learned at medical school should be refined and honed in a practice

context. However, directors of training programs must be aware that, despite the fact that the bodies governing medical school curricula mandate its inclusion, great variability exists in what is actually covered.[18] It can be erroneous to assume that trainees have the skills or confidence required to deliver culturally appropriate care to patients who may come from a wide range of sociodemographic backgrounds and communities.

In this section, the authors first propose what should be taught, and then describe a method for teaching it. Dogra and colleagues[37] suggest the following as essential and core:

Curriculum planners should focus on educational policies to ensure that there is institutional ownership of cultural diversity education and to create a safe learning environment. The learning outcomes must be clear and achievable. The following learning outcomes are suggested as a minimum requirement:

Define *cultural diversity* and apply this definition with respect to clinical practice.

Critically appraise the use of key terms, such as race, ethnicity, culture, multiculturalism, and inequalities of access to health care.

Acknowledge that bias and assumptions are a normal part of intersubjective experience, and then evaluate your own attitudes and perceptions (including personal bias) regarding different groups within society.

Evaluate institutional prejudices and how these relate to your own perspectives.

Identify strategies to challenge prejudice effectively and identify local policy in this area to ensure robustness.

Evaluate and justify the approaches used in your own clinical practice.

Assess the impact (both positive and negative) of your attitudes on your clinical practice and show respect for patients and colleagues who encompass diversity of background, opportunity, language, culture, and way of life.

List the different approaches to developing skills in meeting the needs of diverse populations, and compare and contrast these.

Describe existing equal opportunity legislation.

Explain how you would apply the legislation to your practice as a health care provider and an employer.

Evaluate the relevance of cultural diversity training in health care.

The rationale for these objectives comes from extensive research and teaching in this area. The authors suggest that a need exists to promote all aspects of human diversity (using broad definitions, such as that provided by the AAMC). Finally, culture must not be equated with merely ethnic, racial, or religious difference.

Methods for Teaching Cultural Sensibility

To meet the suggested outcomes, programs must use a range of methods. Whatever approaches are used, most of the teaching will need to allow students to discuss issues, reflect on their perspectives, and relate these to delivering high-quality care that is equitable irrespective of patient background, indicating that seminars allowing discussion should be an integral part of any program.

Selection of readings is particularly important in this type of classroom setting. Readings about particular cultures can be helpful, especially if trainees are able to ascertain broader principles regarding how to engage in dialog with patients and families about cultural views and practices, rather than relying on the learning of simple facts about cultures. Role-playing can be especially useful in this instance because it allows trainees to practice asking open-ended questions and allows them to

become comfortable in bringing these questions to the foreground while also distilling this information from the basic clinical interview. Role-playing also allows interaction by the other trainees observing the situation, and critical feedback on the ways that questions can be either enabling or limiting. The cultural sensibility approach also allows trainees to use role-playing as a means to examine their own biases and prejudices, and bring these forward in a way that is productive and explorative.

The authors find it easiest for the instructor to begin the role-playing exercise as the patient and break from character as needed to facilitate points and discussion. As trainees grow more comfortable with this format, they should begin to play the patient role on a rotating basis. It is also helpful for the instructor to prepare character outlines for the trainees to play as a means to prompt discussion and interaction.

Online educational programs undertaken in groups may be a way of using education tools in the face of limited resources, but educators must be aware of some potential problems. Two major limitations are that students may not really challenge themselves or be challenged in a way that is possible in a more interpersonal learning context. Also, students may go through the motions of an online program but not really engage with the material; this is even more likely if students are resistant or dismissive to the idea of diversity education. Ideally, online programs can serve as an introductory guide that is then followed up with a group activity, during which views can be challenged or modified in response to discussion and reflection. However, some students may find it more comfortable (and perhaps not be challenged enough) to begin these programs alone before engaging in group activity.

Platt and colleagues[38] write about the key aspects of patient-centered interviewing. The key areas that require exploration are:

1. Who is this person? What constitutes that person's life? What are the patient's interests, work, important relationships, and main concerns?
2. What does the patient want from the physician? What are his/her values and fears? What does he/she hope to accomplish in the visit or over the longer term?
3. How does the patient experience the illness or problems?
4. What are the patient's ideas about the illness/problem?
5. What are the patient's main feelings about the illness?

It is arguable that this is nothing more than good psychiatric interviewing and part of a comprehensive assessment, just as are the questions suggested by Kleinman.[31] However, providing culturally appropriate care involves taking these questions and the answers to them one step further. The clinician must consider how the responses to the above questions fit in with the wider world and also with the provider's own perspective. Appendix 1 provides a sample curriculum used by one of the authors.

Whatever method is used to deliver the program, lectures, didactic teaching, and information about specific cultures should constitute very little of the curriculum. Students may find uncertainty uncomfortable,[39] but merely giving them information may provide a false sense of security. Culhane-Pera and colleagues[40] found that residents also preferred receiving information, and there can be a tendency to focus on learning information rather than engaging with one's own world views and how subjective it really is.

Faculty Support and Development

Dogra and colleagues[18] argue that faculty development is an essential component to consider, and evidence suggests that staff do not feel well supported in this area. Senior faculty and staff may also feel less comfortable with this issue.[41] Child and

adolescent psychiatrists will generally be familiar with managing different perspectives, but may still be less comfortable in owning their biases and considering the potential impact of these on their practice. Although most psychiatrists are familiar with the notion of transference and countertransference, blind spots may exist around issues of diversity, with regard to members of cultural groups similar to one's own and others'. Program directors may want to consider how the trainers they manage or coordinate view these issues, and also how they think their trainees might best develop their skills.

Whatever educational programs are developed, the education philosophy, process, contents, and outcomes must be systematically considered. Clarity about the philosophy and outcomes should enable development of a coherent program. All programs should include an expectation that clinicians identify their own biases and assumptions about the patients and families they are likely to encounter. Personal perspectives are crucial to recognize because they impact the clinical consultation.

SUMMARY: FUTURE DIRECTIONS AND RESEARCH AGENDA

The field of cultural child and adolescent psychiatry is a relatively new one, and treatment models and approaches have yet to develop consensus and an evidence base. The cultural sensibility approach builds on present approaches to culture and medical education. It can enable psychiatry trainees to develop a skill set that allows for the interactive gathering of information in a culturally sensitive and open-minded way that recognizes that patients, family members, and clinicians alike must develop an understanding of each other's perspectives.

The future development of child and adolescent psychiatry depends on it being a flexible and adaptable specialty that is able to meet the needs of diverse communities with coherence and integrity. To do so, it must address cultural issues with greater sophistication than earlier models suggest. Cultural sensibility as a model may help provide the field with the essential tools for meeting the needs of changing generations and cultures of patients and families. The authors believe the field must begin to (1) develop more pedagogic techniques to give trainees the tools to meet the needs of their patients, (2) consider the generalizability of this model to other areas of medical education and to the teaching of other health professionals, and (3) develop better methods to assess the technical skills of trainees to effectively practice culturally sensible child and adolescent psychiatry.

A need also exists to test the models and develop better evidence to ensure that they can be modified and adapted to remain dynamic. Recent changes to the structure of the specialty board examinations in psychiatry training programs in the United States have created an opportunity for the faculty to more directly assess a trainee's clinical skill set. This change should include evaluation of the degree to which culture is addressed in the clinical encounter, and also assessment of how this information can be synthesized and used effectively in treatment planning.

Culture may uniquely influence the practice of child psychiatry compared with other disciplines, given that how a society views children is to a lesser or greater extent culturally influenced, as is the behavior they present with. Children are dependent on their families, and the meaning of family and how families respond to children's emotions and behaviors is a complex relationship between the wider culture and the microfamilial culture. This fact has several implications for the field. A need exists to strike a balance between understanding parental concerns and perspectives and those of the child, which are no less important. In trying to balance the wider culture and the culture of their family, young people may

face challenges that lead them to mental health services. To initiate appropriate interventions, clinicians must ensure that they are mindful of their own perspectives and how these interplay with those of the family and the young person. Only if these issues are acknowledged and addressed will it be possible to devise management plans that are clinically sound and also acceptable to the whole family. Any program that purports to teach trainees about providing culturally appropriate care to diverse communities should show that it enables trainees to take into account all perspectives and also the medicolegal contexts the field works in to deliver high-quality clinical care.

APPENDIX 1: SAMPLE CURRICULUM: TEACHING CULTURAL PSYCHIATRY

The approach to teaching cultural psychiatry will be defined by several factors: Is the course free-standing or part of other courses? How many hours are devoted to this topic? How many students are in the course? And, what is the level of experience for the trainees in the course? One example is provided of a small (6–8 students) postgraduate seminar that was 1 hour per week for 6 weeks and taught by one of the authors.

Trainees were assigned to read *The Spirit Catches You and You Fall Down* by Anne Fadiman.[42] This book is an excellent touchstone for discussion because it details the actual events of a young girl in the Hmong community who had epilepsy. The book is useful as a teaching tool because Fadiman carefully weaves the story by presenting both the biomedical perspective of the physicians along with the cultural story of the Hmong family. The clash of cultures emerges over time, and neither perspective ultimately gains primacy; both are given a degree of respect and a degree of criticism.

Through using this book as the focal point of discussion in the first class, students begin to discuss their cultural assumptions and beliefs, especially during the clinical encounter. In this first session, it is important to create a safe classroom space where trainees feel free to express their beliefs without fear of recrimination or retribution. It is also reasonable to set ground rules for the discussion that include a degree of group confidentiality, so that trainees can express their feelings openly and honestly.

The next 3 weeks of the course introduce the cultural sensibility framework using a case-based approach. Trainees are encouraged to bring active cases to the class to discuss and consider. Throughout this section of the course, definitions and readings drawn heavily from anthropology and sociology emphasize the core definitions of concepts while also presenting a model for trainees to incorporate into the clinical encounter. Trainees practice phrasing open-ended questions in nondirective ways to elicit the cultural, spiritual, and identity issues that are key to the patient. In addition, because of the child and adolescent subspecialty training in this class, the trainees are exposed to ways of thinking about the questions they raise in developmentally appropriate ways, and also to differentiate between the culture of the child or adolescent and that of the family and broader society.

The final 2 weeks of the class serve as an opportunity to bring closure to the course. Discussion focuses on transference and countertransference through the lens of culture, and the ways that trainees can establish ways to continue to explore their own biases and lifelong learning patterns.

The structure of this course is just one way of reflecting this material, but it allows trainees and faculty an opportunity for self-reflection and for building a durable framework from which to approach culture in the psychiatric context. This structure can be adapted depending on the size of the class and number of contact hours.

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