Training Child and Adolescent Psychiatrists to Be Culturally Competent

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KEYWORDS

• Child and adolescent psychiatry • Cultural competence
• Education • AACAP model curriculum

Cultural competence is the ability of health care professionals to communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds. Aspects of diversity include—but go beyond—race, ethnicity, gender, sexual orientation, religion, and country of origin.[1] In response to the increasing diversity of many industrialized societies, educational efforts have been aimed at educating medical trainees to address the needs of a heterogeneous patient population. It is imperative that the child and adolescent psychiatric community prepare for the changing world to provide appropriate, accessible, and quality clinical care. The first step toward this goal is to understand the role of culture and cultural competence in clinical care. As the field of cultural competence has evolved, the goal has moved from educating clinicians in the categorical approach—that of becoming skilled at knowledge, attitudes, and practices of a particular cultural group of patients—to a focus on the development of a set of skills and framework. This culturally competent therapeutic stance is an orientation that places medicine and patients in a social, cultural, and historical context. The overall aim is the open acknowledgment of the dignity and autonomy of, and delivery of high-quality medical care to *all* members of society, regardless of gender, race, ethnicity, religion, sexual orientation, language, geographic origin, or socioeconomic background.[2]

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Child Adolesc Psychiatric Clin N Am 19 (2010) 815–831
doi:10.1016/j.chc.2010.08.004 **childpsych.theclinics.com**
1056-4993/10/$ – see front matter

HISTORY

If one were to consider cultural psychiatry as the study of "unusual syndromes" by Western standards, then this field has existed for more than 100 years. It was Darwin who first talked about "primitive" people and described Westerners as possessing "advanced" evolutionary development. This fostered a predetermined value system of judging cultural groups and also influenced the medical assessment of seemingly culture-specific conditions.[3] For example, early colonial physicians condescendingly described unusual symptom patterns as "amok" among Malays as primitive expressions of stress.[4] Kraepelin observed that Western prototypes of mental disorders, although qualitatively variable in their presentations, were essentially culture-free constructs.[3] In 1977, Kleinman argued that these Western constructs of disorders could not be applied uniformly across different cultural contexts.[3] Furthermore, cultural contexts had an important shaping influence on disease categories. Cultural factors could not be subtracted from the disease without modifying its sufficient psychopathologic architecture, presentation, course, or outcome.[5] Also, in Rutter's textbook *Developmental Psychiatry*, he noted that creative capacities of adults and children reflected variations by gender and culture.[6]

Cultural evolutionism was also challenged in the early twentieth century by anthropologists who documented the great variability of social behaviors and stressed the importance of cultural factors in shaping the perceptions and hence the life of an individual.[7] Whiting and Child, in their book *Child Training and Personality,*[8] were the first to examine, in 6 cultural groups, how civilization affected the children in their later behavior. Indeed, cultural psychiatry involves much more than a focus on the "exotic." It embodies the concept that culture is relevant and important in *all* of our clinical interactions and that ongoing attention to cultural factors is *imperative* in the routine provision of clinical care.

Culture consists of the shared values, norms, traditions, customs, arts, history, folklore, and institutions of a group of people. It plays an important role in how people of different backgrounds express themselves, seek help, cope with stress, and develop social supports. Culture affects every aspect of an individual's life, including how we experience, understand, express, and address emotional and mental distress.

Cultural competence is defined as a set of knowledge-based and interpersonal skills that allow individuals to understand, appreciate, and work with individuals of cultures from other than their own. Five components comprise culturally competent care: (1) awareness and acceptance of cultural differences, (2) capacity for cultural self-awareness, (3) understanding the dynamics of difference, (4) developing basic knowledge about the patient's culture, and (5) adapting practice skills to fit the cultural context of the patient and family.[9] Failure to understand the cultural background of children and adolescents and their families can lead to the following problems: misdiagnosis, nonadherence, poor use of health services, and general alienation of the child/adolescent and family from the health care system.[10]

However, it was not until 1994, that a formal framework to assess the impact of culture on mental illness was included in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV).[11] This framework is the Outline for Cultural Formulation (OCF). It remains only in the Appendix along with a glossary of culture-bound syndromes in the current DSM-IV-TR (Text Revision), which was revised in 2000. The OCF includes the following 5 main areas: (1) cultural identity; (2) cultural explanation of the individual's illness; (3) cultural factors related to psychosocial, environmental, and functionality factors; (4) cultural elements of the relationship between the individual and the clinician; and (5) overall cultural assessment for diagnosis and care.

It is noteworthy that the OCF is primarily targeted toward the individual adult, not youth specifically and does not address the role of family, except in a general assessment of the cultural factors related to psychosocial, environmental, and functionality factors. Youth do not exist in a vacuum. The parent-child relationship is profoundly influenced by cultural forces. This relationship is often key to the child's clinical presentation. So, whereas the OCF is a significant contribution to the field of general psychiatry, when working with children and adolescents this framework must be expanded and modified. The cultural formulation must include some assessment of the child's family members and the impact of divergent (or similar) profiles on the child's life and clinical presentation. For optimal clinical care of the child, all 5 areas of the OCF should be touched on for at least the child's parents, and potentially other key individuals in the child's life.

The parents' cultural identity, cultural explanation of the child's illness, and cultural elements of the relationship between the parents and the clinician, are highly relevant to the overall cultural assessment for diagnosis and care of the child. The OCF is most clinically useful when considering all these variables in relation to the family as a whole, not just as they relate directly to the child or adolescent.

We must also assess issues such as the role of "differential" acculturation between family members. An acculturation differential exists when 2 individuals are not at the same level of acculturation. An example of this is a first-generation Mexican mother who speaks only Spanish, does not work outside the home, and adheres to traditional cultural values and gender roles (including the notion that a girl must remain a virgin until her wedding day), with a second-generation Mexican-American teenage daughter who prefers to speak English, identifies herself more with American pop culture than with her Mexican roots, has had several boyfriends, and is currently sexually active. This differential acculturation between parent and child can play a critical role in a youth's clinical presentation, and has even been suggested to be a risk factor for Latina teen suicide attempts and completions.[12]

As part of the OCF family assessment and in general, it is also important to recognize that the diversity that exists within an ethnic group is often overlooked. Even within a family, individuals may belong to or identify with different ethnic subgroups as well as groups. For example, the term Asian American includes people from a variety of nations, such as Afghanistan, China, India, Syria, and Japan. It includes both immigrants and those whose families have lived in the United States for generations. According to 2006 Census estimates, some 44.3 million Americans were identified as Hispanic. Within this group, 64.0% were Mexican, 9.0% Puerto Rican, 3.5% Cuban, 3.0% Salvadoran, and 2.7% Dominican. The remainders are of some other Central American, South American, or other Hispanic or Latino origin.

Until 1984, cultural competence was not stressed in the requirements for residency training in general or child psychiatry by the Accreditation Council for Graduate Medical Education (ACGME). The 1987 edition did not list any specific requirements for cultural training, but recommended broad clinical experience with families from "all social and economic levels." The 1991 revision was significant in that the ACGME required "didactic instruction about American culture and subculture" in addition to supervised clinical experiences with "patients of a variety of ethnic, racial, social and economic backgrounds." The 1995 revision stated that "Residents must receive training so that they have the opportunity to evaluate and to treat patients from various cultural backgrounds and socioeconomic levels." The 1999 revision added "sensitivity to a diverse patient population" as part of *Professionalism*, 1 of 6 core competencies that residents are expected to attain.[13]

Residency programs have responded to the ACGME's cultural competence standards. A 2004 article in the *Journal of the American Medical Association* found that among close to 8000 graduate medical educational programs surveyed in the United States, 50.7% offered cultural competence training in 2003–2004, up from 35.7% in 2000–2001. This was thought to be attributable to the recognition of the increasing diversity of the patient population, in response to pressure from ACGME.[14]

But there are still programs that do not offer formal cross-cultural training. There also seems to be a perception of lesser importance relative to other topics in the training curriculum.[15] Despite increasing requirements by the ACGME for training in cultural psychiatry, there has been little discussion of the content and method for teaching.[16] Some curriculum guidelines of cultural competence have been published.[15] Cultural curricula have been implemented in other disciplines besides psychiatry, including pediatrics and family medicine.[17–19]

MAJOR EMPIRICAL FINDINGS

As mentioned previously, psychiatrists entering medical practice are increasingly likely to provide services to culturally diverse patients. Data from the last census 2000–2050[20,21] show that the minority populations in the United States are increasing at a faster rate than the majority population. From the 2000 to 2050, the proportion of whites in the United States is projected to decrease while the proportion of other racial and ethnic groups (ie, black, Asian, Hispanic) is projected to increase. For child and adolescent psychiatrists, this trend toward diversity in patient population is already a reality. By 2020 the racial and ethnic distribution for school-age persons between 5 and 17 years old is projected to be 30 million white; 9 million African American; 13 million Latino/a; 3 million Asian/Pacific Islander; and 4 million other, which includes American Indians, Alaska Natives, and those of multiple race/ethnicities (U.S. Census Bureau, 2000; http://www.census.gov/census2000/demoprofiles.html). Because of the multifaceted, multicultural, and fluid nature of contemporary society, there are often significant challenges to providing culturally competent mental health services for culturally dissimilar as well as culturally similar therapeutic dyads.

A growing literature delineates the impact of sociocultural factors, race, and ethnicity on health and clinical care.[22,23] Patients present varied perspectives, values, beliefs, and behaviors regarding health and well-being. These include variations in patient recognition of symptoms, thresholds for seeking care, ability to communicate symptoms to a provider who understands their meaning, ability to understand the prescribed management strategy, expectations of care (including preferences for or against diagnostic and therapeutic procedures), and adherence to preventive measures and medications.[24,25] Considerable evidence supports the idea that sociocultural differences between patient and physician can influence communications and clinical decision making.[26] There is also literature that suggests that provider–patient communication is directly linked to patient satisfaction and adherence, and subsequently to health outcomes.[27] Thus, when sociocultural differences between patient and provider are not appreciated, explored, understood, or communicated in the medical encounter, patient dissatisfaction, poor adherence, and poorer health outcomes may result.[25] It is not only the patient's culture that matters; the provider's "culture" is equally important.[28] Historical factors for patient mistrust, provider bias, and their impact on physicians' decision making have also been documented.[25] Failure to take sociocultural factors into account may lead to stereotyping, and, in the worst cases, biased or discriminatory treatment of patients based on race, culture, language proficiency, or social status.[25]

HEALTH CARE DISPARITIES AND CULTURAL EDUCATION

In the United States, the results of these challenges can be seen in the existence of health care disparities.[29,30] The 2000 Institute of Medicine (IOM, 2001) Report, *Crossing the Quality Chasm,* listed patient-centered care and equity as 2 of 6 objectives that need to be met to improve quality of health care in the United States.[31] The 2002 IOM Report,[32] *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,* was a landmark report that concluded that racial and ethnic disparities exist in health care and are unacceptable because they are associated with worse outcomes in many cases. The report defined "disparities" in health care as racial and ethnic differences in the quality of health care that are not attributable to access-related factors or clinical needs, preferences, and appropriateness of intervention. The 2002 report analyzed this evidence of disparities focusing on the operation of health care systems and the legal and regulatory climate and on discrimination at the individual patient provider level. Discrimination was defined in the report to refer to differences in care that result from biases, prejudices, stereotyping, and uncertainty in clinical communication and decision making. The report made 21 recommendations relating to education, which included increasing the proportion of underrepresented US racial and ethnic minorities among health professionals as well as integrating cross-cultural education into the training of all current and future health professionals. The 2004 Institute of Medicine report,[33] *In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce,* summarized the evidence demonstrating that greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, better patient-provider communication, and better educational experiences for all students while in training. Many organizations, including the American Medical Association (AMA), have adopted recommendations made by these 3 IOM reports, of which training and education to increase physician cultural competency continues to be a strong focus. A year earlier in 2001, the Office of the Surgeon General had determined that in comparison with whites, ethnic minorities in the United States had less access to mental health care, were less likely to receive quality or expert care, were more likely to be misdiagnosed, and reported less effective mental health treatment.[30] The report cited considerable evidence that found that a disproportionate numbers of African Americans are represented in the most vulnerable segments of the population— people who are homeless, incarcerated, in the child welfare system, victims of trauma—all populations with increased risks for mental disorders. As many as 40% of Hispanic Americans report limited English-language proficiency. Because few mental health care providers identify themselves as Spanish speaking, most Hispanic Americans have limited access to ethnically or linguistically similar providers. The suicide rate among American Indians/Alaska Natives is 50% higher than the national rate; rates of co-occurring mental illness and substance abuse (especially alcohol) are also higher among Native youth and adults. Although some investigators have done important work (see the article by Kataoka and colleagues elsewhere in this issue for further exploration of this topic), even more data are needed with this population, so the full nature, extent, and sources of these disparities remain largely hypothetical. Both Asian Americans and Pacific Islanders who seek care for a mental illness often present with more severe illnesses than do other racial or ethnic groups. This, in part, suggests that stigma and shame are critical deterrents to service use. It is also possible that mental illnesses may be undiagnosed or treated later in their course because they are expressed in symptoms of a physical nature. The Youth Risk Behavior Survey of the Centers for Disease Control and Prevention[34] reports that

Latino and African American youths now have significantly higher rates of suicidal ideation and attempts compared with European Americans.

Based on the preceding information, many recommendations were made in the Surgeon General's report, out of which one was most relevant to education:

> *"Minorities are underrepresented among mental health providers, researchers, administrators, policymakers, and consumer and family organizations. Furthermore, many providers and researchers of all backgrounds are not fully aware of the impact of culture on mental health, mental illness, and mental health services. All mental health professionals are encouraged to develop their understanding of the roles of age, gender, race, ethnicity, and culture in research and treatment. Therefore, mental health training programs and funding sources that work toward equitable representation and a culturally informed training curriculum will contribute to reducing disparities."*[30]

It is evident from the previously cited empirical findings and the emphasis by medical education governing bodies that training our child and adolescent psychiatrists to be culturally attuned is not only imperative for optimal clinical care of our patients, but is the new frontier for competent training. Proper training in cultural psychiatry leads to increased awareness of social, cultural, and political issues that can enhance the effectiveness of clinical work. Attention to culture in psychiatric care also serves to articulate a vision of a pluralistic community that respects diversity. The effects of globalization on increased flows of knowledge and the confrontation of different value systems heighten the importance of cultural psychiatry both as an academic discipline and as a central pillar of clinical training.[3]

CULTURAL COMPETENCY CURRICULA IN CHILD AND ADOLESCENT PSYCHIATRY

Many organizations in American psychiatry recognize the need for formal training in cultural issues, and the development of cultural competency curricula in child and adolescent psychiatry training programs has been encouraged by many organizations, including the AMA, the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry (AACAP), ACGME, American Association of Directors of Psychiatric Residency Training Programs (AADPRT), and the Residency Review Committee (RRC).[29] Several sample curriculum modules have been published.[35–39] Weissman and colleagues[40] found that there is a cohort of residents who feel unable to handle certain cross-cultural interactions at the time they finish training. This ranged from roughly 5% of study subjects not knowing how to address a patient in a culturally competent manner to 28% feeling very or somewhat unprepared to treat patients who had some distrust of the US Health system.[a]

The process of teaching about cultural competency has developed over the past 30 years, with the ideal course having evolved from a few didactic sessions focused on characteristics of minority group members, to a scaffolded multiyear curriculum encompassing an in-depth understanding of health care disparities, and exploring the knowledge, skills, and attitudes inherent in becoming a physician specialist able to provide culturally competent care in a multicultural society. There is wide recognition

[a] The first 3 organizations, the American Medical Association (AMA), American Psychiatric Association (APA), and the American Academy of Child and Adolescent Psychiatry (AACAP) are guild organizations that perform several functions, including representing the interests of practicing physicians and sponsoring education to physicians as well as the community-at-large. The latter 3, the Accreditation Council of Graduate Medical Education (ACGME), American Association of Directors of Psychiatric Residency Training Programs (AADPRT), and the Residency Review Committee (RRC) are responsible for oversight of graduate medical education programs.

throughout health care education that cultural competency concepts are integral to the care of patients. Anandaraja and colleagues[41] describe the development of a Global Health Residency Track that includes a core competency area "Health disparities, Human rights, and Cultural competency." This issue is equally relevant in dentistry, with recognition of the presence of dental disparities, a lack of diversity in the workforce, and dental schools continuing to integrate cultural competency concepts into their curricula.[42] Similarly, a variety of methods, including team-based learning, have been found useful in teaching cultural competency concepts to pharmacy students.[43] Although synonymous terms are "culturally effective health care" and "culturally effective pediatric care" (from the American Medical Association and from the American Academy of Pediatrics), the term "cultural competence" is more ubiquitous, and used throughout the various medical specialties. A newer, more process-oriented model, the "cultural sensibility" approach,[44] is described in detail elsewhere in this issue. Ideally, cultural competence related to the provision of health care will be couched in an understanding of health disparities, and the role of the health care provider in minimizing these disparities and ensuring the provision of care that is patient- and family-centered.[45] Such cultural education is no longer confined solely to the care of "minority patients," but is understood to extend to the more complete continuum of culture, including "the full spectrum of values, behaviors, customs, language, race, ethnicity, gender, sexual orientation, religious beliefs, socioeconomic status, and other distinct attributes of population groups."[46] Each of these is important, but may not receive needed attention in teaching. Of note, as of this writing, there are 381 languages spoken in the United States.[47] Although some studies have indicated the reverse, Boudreau and colleagues[48] found that language concordance was not required for patient satisfaction in cross-cultural interactions with pediatric patients; providers that used interpreters and were perceived as culturally competent had a positive impact with the parents' perception of how their care was delivered. The proper use of interpreters is a critical skill. Another significant cultural factor is an understanding of the impact of spirituality and religion. The cultural competency curriculum should provide an opportunity to examine religious practice, ethnic variations of the major faiths, and the cultural impact of spiritual observance on development.[49]

As also written about by Karnik and colleagues,[50] and Pumariega,[51] developmental formulations are an inescapable aspect of cultural child and adolescent psychiatry that may not be considered in other medical specialties. In creating a learning experience for trainees, the concept that normal behaviors and interactions are culturally determined must not be forgotten. Developmental milestones as varied as the age to start toilet training, the age when a child can stay at home alone, go out on a first date, or move out of the parents' home[4] may all have a good deal of cultural variability. With the ubiquitous presence of social networking and online information portals, providers ought to presume that the children of today are most likely being raised in a culture (quite) different from that of their parents'. Thus, attending to the therapeutic alliance not only with the patient, but also with the parent (and often, the teacher) becomes ever more important. Parents must feel that the provider conceptualizes the problem from their point of view, whereas the patient (especially true for teens) must feel that the psychiatrist is their ally, and not simply an agent of the parent. As such, skillful culturally attuned providers may have to play the roles of agent and ally to both parties.[45,52]

BARRIERS TO IMPLEMENTATION OF A CULTURAL COMPETENCY CURRICULUM

Barriers to cultural competency training may be institutional, logistical, or individual. An often-noted institutional barrier is that of available didactic time.[53] This is likely

compounded by the perception that these topics are less important in clinical training.[54] An example of both institutional and logistical barriers is teaching about the use of interpreting services. The cost of interpreting services is a potential barrier to their use, which could be minimized by adequate third-party reimbursement.[55] Even when interpreting services are available, there must be consistent use by faculty and senior house-staff to effectively teach this skill to junior house-staff and students. Time constraints are a common explanation for failure to use existing services. Intuitively, one might expect that individual factors would be significant. This is borne out in the literature,[56] and measures are being developed to assess the ability to use interpreters effectively as part of medical practice.[57]

Another barrier is the appreciation that learning about cultural competence is the knowledge of what it is and what it is not. Cultural competence training is not the same as diversity training, which typically consists of much more general information that may not be provided in the framework of a particular social context.[45]

The sense of discomfort that may arise when the concept of bias is discussed between individuals with different cultural, racial, or ethnic backgrounds presents another roadblock to the implementation of such curricula. An example is the trepidation that may be experienced by the faculty member of color teaching a group of white residents about cultural competence.[58] Cultural competency is often a topic that some learners indicate they do not wish to learn about. As a result, these students may be particularly vocal in disputing the information provided, perhaps even "punishing" or "harassing" the instructor of the topic.[59] One might conceptualize that these learners are early in their personal development of cultural competency, and would do well to adopt Step 1 of the cultural sensibility approach (see the article by Karnik and Dogra elsewhere in this issue for further exploration of this topic), which consists of self-reflection of one's own experiences with cultures other than one's own, and potential biases. Some learners may even be most comfortable with ethnocentric monoculturalism, which is the predisposition of the majority (European American) culture to ignore or devalue other cultures.[58,60] It may be difficult to approach the concept of institutional, as well as individual racism. The topic of micro-insults (or micro-aggressions) is a necessary but difficult concept that involves "subtle verbal and non-verbal insults directed toward non-Whites, often done automatically and unconsciously. They are layered insults based on one's race, gender, class, sexuality, language, immigration status, phenotype, accent or surname….Micro-aggressions are also cumulative and cause unnecessary stress to people of color while privileging whites…."[61] Bias is a topic that may be difficult to approach because of the sensitivity of some learners. Care must be taken to help students overcome initial discomfort.

Dogra and colleagues[44] reviewed suggestions to overcome barriers in embedding diversity into the medical curriculum. While designed for the undergraduate medical curriculum, there are several principles (noted by **) that can easily be generalized to the training of child and adolescent psychiatrists:

1. Design a diversity and human rights education institutional policy
2. Create a safe learning environment**
3. Develop clear and achievable learning outcomes**
4. Develop content focused on the diversity of human experience (not simply race and ethnicity)**
5. Raise awareness of students' own biases and prejudices**
6. Integrate cultural diversity across the entire curriculum**
7. Make diversity patient-centered**
8. Teach outside the classroom and hospital setting**

9. Form multidisciplinary teams of educators**
10. Make training of faculty compulsory**
11. Develop clear and comprehensive assessment of policies, delivery, and learned outcomes of cultural diversity education.
12. Map what others are doing and challenge yourself as a role model.

It is useful to learn the institutional policy of the medical school and extrapolate that to the current didactic curriculum with specific learning objectives. For learners who are uncomfortable with the topic, couching this information in such a background can make it more palatable, and it may seem less personally directed. In addition, students and faculty must feel safe to discuss issues related to bias and discrimination to explore the impact of these on working with patients/families, and each other. In our experience, delving into such concepts in large or small group settings is potentially self-revealing with a risk for embarrassment or the potential for reprisal or rejection by others. Permission to speak frankly with colleagues in the spirit of mutual learning must be specifically sought and granted during the teaching process to help this work progress. Without this, reluctant learners may become more hostile or simply shut down and not participate.

It is helpful modeling if not just 1 or 2 faculty members are concerned about the effects of the variety of aspects of culture on patient presentation and care. As child and adolescent psychiatry training is often conducted in concert with psychology and social work training, the use of other disciplines in teaching cultural competency again models the need for all team members to consider these concerns in our work. If limited faculty are involved in this work, the topic may be marginalized and perceived by students as less important. The wider the range of faculty members that recognize, engage in, and express cultural aspects of work with their patients, the more likely it is that this behavior will become part of the academic culture.

Residents and students have been found to be more likely to have previous experience with multiculturalism during medical school and college than faculty members. They may have higher levels of comfort with, for example, sexual orientation issues and learning about non-Western approaches to the practice of medicine. As a result, one must consider that teaching about sociocultural aspects of diversity may not be purely a top-down experience. Learners may be able to provide new knowledge for faculty as well.[62]

CURRICULUM DEVELOPMENT

Dolhun and colleagues[63] note 8 specific content areas that can be covered in a cross-cultural education curriculum(p616) (**Box 1**).

In developing a cultural competency curriculum for subspecialists in psychiatry, such as child and adolescent psychiatrists, the development of specific objectives is key, particularly in light of the resistance that may come from trainees who are at earlier stages of cultural competency development, with less understanding both of the material and of the cultural attunement process. Clear objectives help concretize the need for the nuances of cultural competency that must be covered.

The August 2008 issue of *Academic Psychiatry* is a review of cultural competency in psychiatric education and is an excellent resource in developing a curriculum.[64] One example, the University of Toronto psychiatry cultural competence curriculum, is integrated throughout training beginning in the postgraduate year (PGY)-1 and ending in the PGY-5 year.[65] It is designed around the idea of competencies, each designated by the Canadian Medical Education Directions for Specialists (CanMEDS) paradigm. This

Box 1
Eight specific content areas that can be covered in a cross-cultural education curriculum

General concepts of culture (culture, individual culture, group culture)

Racism (racism and stereotyping)

Doctor-patient interactions (trust and relationship)

Language (meaning of words, nonverbal communication, use of interpreters, coping with language barriers)

Specific cultural content (epidemiology, patient expectations and preferences, traditions and beliefs, family role, spirituality and religion)

Access issues (transportation, insurance status, and immigration/migration)

Socioeconomic status (SES)

Gender roles and sexuality

Data from Dolhun EP, Muñoz C, Grumbach K. Cross-cultural education in US medical schools: development of an assessment tool. Acad Med 2003;78:615–22.

model delineates the roles of the physician specialist as a communicator, collaborator, manager, health advocate, scholar, and professional.[66] These are very similar to the Core Competencies of the ACGME: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.[67] Cultural Competency curricula span each of the categories in both models. Cultural Competency concepts span the 6 competencies and 7 roles of a physician and are delineated in **Table 1**.

In considering topics and specific content to be taught, as well as evaluated, the efficacy of the curriculum, an additional resource is the community. Bell and colleagues[58] note the importance of involving the community not only in research-related academic pursuits, but in practice-related matters, particularly in working with children and families that have a history of trauma. This can help prevent additional traumatization by health care providers through decreasing the number of micro-aggressions that are inadvertently committed by these providers.

The Committee on Culture and Diversity of the AACAP has developed a model curriculum for teaching cultural competency in child and adolescent psychiatry training programs, and the authors of this article have been involved in this project.[68] We have delineated 3 major goals to be covered by the end of child and adolescent psychiatry training.

Goal 1: Define the concept of cultural competence and describe its application in the practice of child and adolescent psychiatry with regard to knowledge, skills, and attitudes.
Goal 2: Differentiate normal development from pathology within the concept of cultural identity.
Goal 3: Describe the cultural competence model of service delivery and systems-based care. This includes the development of skills and the necessary attitudes and perspective to work in or consult to a system that provides care for children from culturally diverse populations and their families.

These goals can be integrated into currently existing topics and do not have to be separated into a separate course, although we have developed 3 model courses, with 6, 8, or 10 sessions throughout the training program. There are specific objectives

Table 1
Seven roles of a physician

ACGME Competencies	Definition	CanMEDS Roles	Definition
Patient care	Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health	Health advocate	Responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations
Medical knowledge	Demonstrate knowledge of established and evolving biomedical, clinical, epidemiologic and social-behavioral sciences as well as the application of this knowledge to patient care	Medical expert	Integrate all of the roles of CanMEDS, applying medical knowledge, clinical skills, and professional attitudes in their provision of patient-centered care
Practice-based learning and improvement	Demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence and to continuously improve patient care based on constant self-evaluation and lifelong learning	Scholar	Demonstrate a lifelong commitment to reflective learning as well as the creation, dissemination, application and translation of medical knowledge
Interpersonal and communication skills	Demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals	Communicator	Effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the physician experience
Professionalism	Demonstrate a commitment to performing professional responsibilities and an adherence to ethical principles	Professional	Committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behavior
Systems-based practice	Demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care	Collaborator and Manager	Effectively work within a health care team to achieve optimal patient care; and integrate participants in health care organizations, organizing sustainable practices, making decisions about allocating resources, and contributing to the effectiveness of the health care system.

Abbreviations: ACGME, Accreditation Council of Graduate Medical Education; CanMEDS, Canadian Medical Education Directions for Specialists.

within each goal that are identified as more or less complex by level of competency. Basic competency is the minimum level of cultural competency that a fellow should have on completion of child and adolescent psychiatry training. The next stage is intermediate, that level of cultural competency for a practitioner who is working in a community with a diverse patient population. Finally, advanced is the level of cultural proficiency to which a practitioner can aspire as a result of experience and scholarship.

We have identified several techniques for didactic sessions involving both passive and active learning techniques, including the use of several different movies and films. Because child and adolescent psychiatry fellows come from a diversity of training backgrounds and initial cultural competency work may have begun during medical school and/or general psychiatry training, a needs assessment is an appropriate way to ensure what topics most require coverage for each cohort of trainees. For each goal we have defined basic, intermediate, and advanced level competencies. These competencies can be cross-linked with the ACGME (and CanMEDS) competencies to help illustrate how cultural competency affects the functioning of a child and adolescent psychiatrist. Suggested methods for teaching each goal and a reference list are also provided. This curriculum will be available through the AACAP Web site (www.aacap.org).

EVALUATION

Although evaluation of a curriculum is typically regarded as important, there has been no consensus on how best to determine the impact of a cultural competency curriculum. The Tool for Assessing Cultural Competency Training has been developed to assess the presence of relevant topics in the medical school curriculum.[69] Using Miller's model (**Fig. 1**) to assess the learner's use of the information,[70] the pretest/posttest has been used to show the "knows" or "knows how." The Objective Structured Clinical Examination (OSCE) has been found to demonstrate that the learner can "show how" to use the knowledge. "Does" seems most effectively measured by the attending psychiatrist during observation of the resident with a patient. An evolved and useful adaptation of Miller[70] can be accessed at http://www.gp-training.net/training/educational_theory/adult_learning/miller.htm.[71]

One measure, the Intercultural Development Inventory, is a validated instrument found to be useful to assess the intercultural sensitivity of medical trainees before and after cultural training.[72] It has been found applicable to other professions as well, and its use simply requires (brief) formal training. Despite these measures, there remains a dearth of readily implementable evaluation tools to assess the efficacy of training and curricula.[73] Development of these measures is in progress,[53] and should include a variety of formative as well as summative components.[65]

FUTURE DIRECTIONS

The cultural sensitivity curriculum outlined in this article is based on the premise that teaching cultural psychiatry is a process of reflection on the ethological, social, and historical origins and contemporary meanings of culture in child psychiatry theory and practice. This involves questioning some of the assumptions of pediatric psychiatry that may be rooted in limited ethnocentric research that ignores cultural context. The hope is to inculcate in our trainees an open-mindedness to integrate the values and ideas of self and person that may be rooted outside of European American traditions. Clearing a space where one can begin to think about alternative ways of being

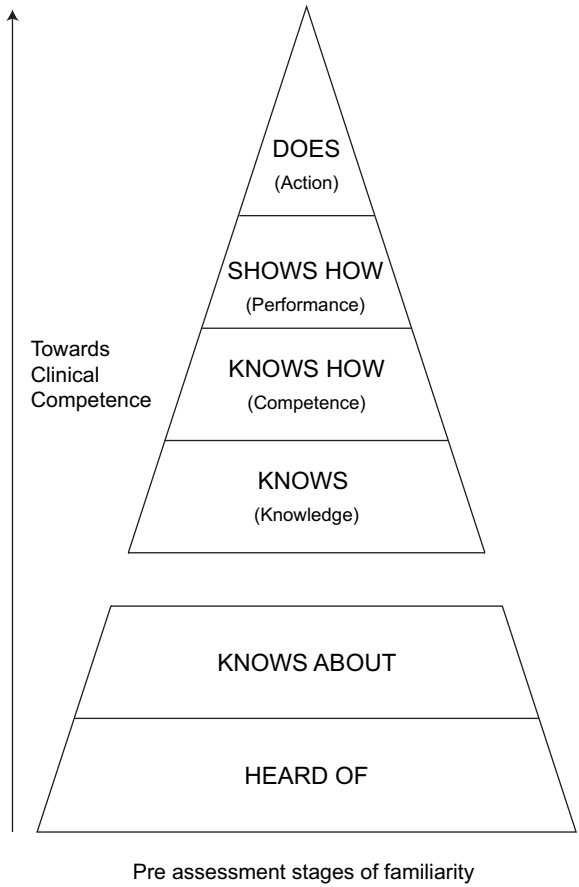

Fig. 1. Miller's prism of clinical competence (A.K.A. Miller's Pyramid). It is only the "does" triangle that the doctor truly performs. (*Based on* work by Miller GE. The assessment of clinical skills/competence/performance. Acad Med 1990;65(9):63–7 (with credit to adaptations by Drs R. Mehay and R. Burns, UK, January 2009); with permission.)

allows for more open dialog and negotiation with patients in clinical settings, as well as suggests fruitful topics for research and clinical innovation.[74]

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