

SYSTEMS-BASED PRACTICE

CULTURAL CONSIDERATIONS IN SYSTEMS-BASED PRACTICE

Updated April 2020

SYSTEMS-BASED PRACTICE: CULTURAL CONSIDERATIONS OBJECTIVES*

Knowledge

The resident will demonstrate an adequate knowledge of:

- 1) The meaning of the terms, “culture” and “cultural competence.”
- 2) The different levels of knowledge and skills, as identified within the cultural competence continuum.
- 3) The various cultural domains that have an impact on individual patients, including the cultural domains of individuals, families, communities, and systems.
- 4) How cultural values and beliefs impact family organization, roles, and function.
- 5) How cultural considerations impact normal emotional and cognitive development, family function, and the expression of psychopathology in children and youth.
- 6) How values and beliefs of particular cultures influence the understanding of mental illness and emotional disturbances, symptomatic and linguistic expressions of psychiatric disorders, help-seeking behaviors, the use of alternative healers, negative attitudes and stigma, and expectations from treatment.
- 7) The risk factors that impact the mental health of immigrant children and their families.
- 8) Disparities that may negatively impact at-risk youth and their families.
- 9) Commonly seen conflicts between systems and families.
- 10) The opportunities for the child and adolescent psychiatrist in learning about cultural considerations.
- 11) The role and limitations of evidence-based medicine, as it pertains to the care of specific minority groups, and those mental health treatments that have an evidence-base for use with minority populations.
- 12) The role of linguistic competence in supporting cultural competence.
- 13) The role of the child and adolescent psychiatrist in advocacy.

Skills

The resident will demonstrate the ability to:

- 1) Identify the demographics and population trends of the communities in which the resident is practicing, including the ethnic and racial mix, the languages spoken, the socioeconomic status, as well as the religious and spiritual beliefs of community members.
- 2) Obtain relevant historical information about how a child’s family interprets and practices their culture and cultural heritage on a daily basis, and how this influences the child’s normal development and expression of emotional or behavioral disturbance.
- 3) Elicit historical information about the specific risks faced by minority groups being served, particularly traumatic and stress factors, as well as issues relating to access and availability of care.
- 4) Obtain culturally-based information from youth and families in a manner that is non-threatening and welcoming, and that facilitates the development of trusting relationships.

- 5) Identify and support the use of community and natural supports as part of culturally competent practice that promotes family empowerment.
- 6) Identify and support system of care policies and service designs that are culturally inclusive, as a way to address patient needs and promote family empowerment.
- 7) Address the power differential between minority families and mental health care providers and support minority families effectively to advocate for their child.
- 8) Identify strengths and resources that diverse families and their communities bring to the care of their children with mental illness and emotional disturbances, and be able to mobilize these and coordinate them with formal services.
- 9) Effectively use interpreters not only for linguistic support but also for cultural consultation.

Attitude

The resident will demonstrate the commitment to:

- 1) Respect different cultures of all types.
- 2) Recognize and explore one's own cultural beliefs and biases so as to minimize their impact on the diagnosis and treatment of diverse children and families and enhance sensitivity to the role culture plays in our identity.
- 3) Learn about the cultural values of diverse individuals, families, and systems and avoid stereotypes.
- 4) Promote, advocate for, and model the provision of culturally competent care to youth and families.
- 5) Promote, advocate for, and model respectful interaction among systems and their representatives, whereby the strengths, mandates, and limits of each system are respected and each team member is valued.
- 6) Advocate for improved access to services of high quality for diverse children and their families, and for the reduction of unnecessary bureaucratic and linguistic barriers to care.
- 7) Enhance humility in the face of cultural difference and in the clinical encounter.
- 8) Fight against racism, xenophobia, and discrimination of every sort, and their adverse impact on the mental health of diverse children and families.

****Appendix 1 describes the systems-based practice competency in the RRC Program Requirements**

OVERVIEW

This module provides a review of cultural considerations for child and adolescent psychiatrists (CAP) who interact with youth serving systems, (e.g., primary health care, education, child welfare, juvenile justice, etc.), that serves diverse population. The goal of this module is to broaden the resident’s knowledge, skills, and attitudes about culture to provide culturally competent care. Cultural competence can enhance the skills of child and adolescent psychiatrists in such roles as direct care provider, consultant, administrator, and policy maker, when working with youth and families from culturally diverse backgrounds and with diverse systems that serve these youth and their families.

This module on cultural considerations is relevant across all of the ACGME Core Competencies, in addition to Systems-based Practice. Explicit reference to the importance of cultural factors in the ACGME core competencies is made in Patient Care (#3), Medical Knowledge (#5), Interpersonal and Communication Skills (#1 and 2), and Professionalism (#5).¹ It is also recommended that the CAP fellows refer to the AACAP Practice Parameters for Cultural Competency for background information and further enrichment on cultural competence.²

Residents should be guided in pursuing group discussion regarding their own past experiences with cultural diversity and explore personal biases to illustrate the impact of culture on therapeutic alliance and treatment decisions. Whenever possible, additional input from members of diverse cultural backgrounds should be included in training on cultural competence, in order to amplify and celebrate the richness of perspective represented in culturally diverse populations.

TABLE OF CONTENTS

I.	The concept and implementation of cultural competence.....	4
a.	Important definitions.....	4
b.	The Cultural Competence Continuum – Levels of Cultural Competence.....	4
II.	Domains of culture - Ecological model.....	5
III.	Learning to be a culturally competent CAP.....	7
a.	History and formulation.....	7
b.	Incorporating Cultural understanding into the clinical conceptualization.....	8
c.	Treatment interventions.....	9
d.	Keeping it in the community.....	9
e.	Access to care and help-seeking behaviors.....	9
f.	Familiarity with legislative and policy decisions.....	10
IV.	Challenges and consequences related to culture.....	10
a.	Disparities.....	10
b.	Conflicts between families and service providers.....	10
V.	Conclusion.....	11

I. THE CONCEPT AND IMPLEMENTATION OF CULTURAL COMPETENCE

Cultural considerations and cultural competence play an important role in the work of a child and adolescent psychiatrist, not only as a direct care provider, but also as a consultant, administrator, and policy-maker. While there are commonalities among cultural groups, an understanding of cultural competence also requires the recognition that all individuals and families have their own distinctly unique interpretations and practice of their cultures.

Definitions:

Culture - Integrated pattern of human behaviors including thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social nature.²

Cultural competence -Set of congruent behaviors, attitudes, and policies found in a system, agency, or professionals that enable them to work effectively in a context of cultural difference.

The Cultural Competence Continuum – Levels of Cultural Competence

Because the pursuit of cultural competence is a developmental process, it is beneficial for practitioners, agencies, and systems to engage in periodic self-assessment. The cultural competence continuum, which identifies six levels ranging from least to most culturally competent, provides a useful tool for self-assessment. Cross et al. identified six progressive points or levels along the continuum, with cultural destructiveness at one extreme, “cultural competence” at the fifth level, and “cultural proficiency” at the sixth and most advanced level.³

Cultural destructiveness – Cultural destructiveness is the most negative level. It involves attitudes and practices that are destructive to cultures and consequently to individuals in these cultures. With cultural destructiveness, the minority culture is disenfranchised, controlled externally, and at the extreme, exploited.

Cultural incapacity – With cultural incapacity, there is a lack of capacity to help children and families of color and their communities. There is no conscious intent to be culturally destructive, but some assumptions and practices are nevertheless discriminatory and/or paternalistic.

Cultural blindness – At the middle of the continuum, cultural blindness involves an intended philosophy of being unbiased, with the agency or individual embracing the idea that “we are all the same.” This approach, however, disqualifies the relevance of color, race, and culture to service provision, and a truly individualized approach to treatment and treatment planning is undermined.

Cultural pre-competence – With cultural pre-competence, there is recognition of limitations of services and staffing, and an effort to improve. However, at this level risks may include a false sense of accomplishment, with only partial improvement. An example of this is tokenism with regard to hiring a diverse workforce.

Cultural competence – The term cultural competence here represents a form of advanced competence, with acceptance and respect for differences and a commitment to incorporate

new knowledge and service models to better meet the changing needs of minority populations.

Cultural proficiency – At this most advanced end of the continuum, culture and cultural differences are valued and seen as strengths, and there are continual efforts to augment knowledge and improve practices. There is also advocacy for cultural competence throughout the system and for improved relations among diverse groups.

II. DOMAINS OF CULTURE (ECOLOGICAL MODEL)

Consideration of cultural issues in systems-based practice requires recognition that there are different domains of culture, all interfacing with a particular individual youth. These domains include the culture of 1) the individual youth, 2) his or her family, 3) the larger community and society in which the youth and family currently live, 4) as well as the values and biases of each professional discipline and larger systems involved with the youth and family. Within each domain, it is important to identify the significant variables, and then consider which elements constitute protective factors and which constitute potential risk factors for the youth and family.

1. Individual youth domain: The cultural parameters include the age of the youth, national origin, race, ethnicity, generational status (i.e., 1st, 2nd, 3rd generation in the dominant culture), gender, sexual orientation, spiritual/religious beliefs, disability and different ability, socioeconomic class, and developmental status. In addition, each individual youth incorporates language, traditions (such as arts, attire, customs, food, etc.) and group affiliations (such as sports teams, gang membership) and other group identification (such as being an emo or “Goth”) into his or her own unique cultural identity.
2. Family domain: This domain includes the cultural beliefs and practices from the family’s country of origin, which frequently differ and are at odds with the dominant culture where the family is now living. Acculturation, the process of absorbing the new culture, is a challenging process that is both a source of growth and stress for families and their members.² The degree of acculturation may vary within a family, and depends on factors such as socioeconomic status, generational status, linguistic capacity, and community environment (such as living in an ethnic enclave or in a dominant culture community). Depending on the level of acculturation, the individual and their families may be following different modes namely: assimilation, integration, insulation and estrangement as a complex interaction between home and host culture.

Children often become more rapidly acculturated than their parents and other elders due to their neurocognitive and linguistic flexibility and greater exposure to dominant culture values in school and peer contexts. Among caregivers, there may be differences in acculturation. This may create tension for example when one parent is more fluent in the new language than the other or when the youth is more fluent in the new language than any of the caregivers. This may lead to significant intergenerational conflict and needs to be addressed by the treatment team.

Within the family domain the CAP should also assess for a history of immigrant-related loss or trauma and address these concerns in treatment.² It is important to recognize that immigrant families come to America for different reasons and under different circumstances. While some come on a carefully planned basis in order to seek greater Opportunity, many families emigrate as refugees or victims of genocide, following instability in their country of origin.

Migration can present with unique set of opportunities and challenges for families. It is therefore important for the CAP to consider the possible traumatic history of immigrant families, not just the challenges associated with resettlement. These can be divided into: 1) pre-migration stress, such as exposure to violence, persecution and torture in the country of origin; 2) migration stress, including the disruption and separation of families, traumatic journeys, detention in refugee camps and various forms of victimization, such as abuse by smugglers; 3) post-migration and acculturation stress, resulting from low levels of education and job skills, living in high risk neighborhoods, with high exposure to crime and violence, and overcrowded, poor quality inner city schools^{4,5,6}. As a result of these stressors, the immigrant children are at a higher risk of mental health and academic problems.

Assessment of the family domain also involves understanding the family structure (nuclear vs. kinship), preferred language, values, and traditions. Despite certain similarities that families from a specific country or region might share, it is important to appreciate that every family has its own unique interpretation of their culture. This means that the CAP should be prepared to gain both general cultural knowledge and cultural uniqueness, as well as to issues of cultural trauma, cultural transmission, and acculturation.

A broadly based clinical literature identifies common cultural characteristics found in traditional minority families, as compared to those of acculturated families and families affiliated with the dominant culture. In immigrant and other traditional minority families, kinship networks tend to play a greater role than in dominant culture nuclear families, and unwavering respect towards parents and elders is highly valued. Roles to children are commonly assigned based on birth order, and older children are expected to help care for younger ones. In addition, group interdependence and collectivism tend to be more valued than individualism, and there may be less emphasis on individual achievement than on group cohesion and adaptation.⁷ Separation and individuation, a developmental process that is highly prized in Western psychology, is relatively unknown and even seen as maladaptive in other cultures, where adult children may never leave the traditional family home even after they marry and have their own children.

3. All staff involved in the child-serving systems operates within their own perspectives based on previous life experiences, education and training, identified work roles, and the culture and legal mandates of their specific professional discipline. In turn, each child and family serving system has its own organizational values and biases and is mandated to follow local, state and federal statutes and regulations, which are largely shaped by the values, beliefs, and practices of the dominant culture. These systems each have their own unique history, philosophy of delivering mandated services, and methods of accountability.

4. Each system also has national organizations and federally funded entities that disseminate best practices, identify service gaps, fund new state initiatives, educate and set standards for professionals, educate the lay public, and promote professional values. Within mental health, such organizations include the National Institute of Mental Health (NIMH), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Joint Commission (JC), national professional organizations, and state licensing boards.

III. LEARNING TO BE A CULTURALLY COMPETENT CAP

Cultural competence can be applied to the history of present illness, formulation, clinical conceptualization, normal development, and treatment interventions in the following way:

History and formulation:

Many ethnically diverse families have limited English language competency and hence may face multiple barriers while seeking care and conveying their needs to providers. The language used to communicate with ethnically diverse families plays a critical role in establishing a therapeutic alliance and obtaining accurate clinical information. Clinicians should conduct the evaluation in the language in which the family is proficient.² While a provider can strive towards cultural competence, linguistic competence can be difficult to achieve. Hence it is important that the interview and the feedback be carried out with the aid of certified and trained language interpreters. It is not a good clinical practice to utilize either the child or another family member to interpret for the family, as it causes a shift of power/ hierarchical differential in the family.^{2, 8} Treatment consents, informational, educational material and scales and treatment planning instruments should also be translated into the family's language.

CAPs should apply their knowledge of cultural differences in normal development, expressions of distress, and presentation of symptoms to the clinical formulation.² It has been shown that cognitive, motor, and social development may differ across cultures. Children from diverse ethnic backgrounds have also been found to display different patterns of symptomatology. Variability in cultural expressions of emotional and psychological distress may lead to misdiagnosis and improper treatment. Accurate assessment of cultural manifestations of distress can prevent misdiagnosis and erroneous treatment.²

The DSM5 Outline for Cultural Formulation can be utilized to develop an optimum socio-cultural formulation. The DSM 5 provides a revised version which calls for systematic assessment of five distinct categories: 1) *cultural identity of the individual*, comprising the individual's racial, ethnic, or cultural reference groups as well as other relevant aspects of identity, such as degree of involvement with the culture of origin versus host culture, religion, socioeconomic background, place of origin, migrant background, and sexual orientation; 2) *cultural conceptualization of illness*, including the influence of cultural beliefs on the individual's experience, conceptualization, and expression of symptoms or problems; 3) *psychosocial stressors and cultural features of vulnerability and resilience*, including key stressors and supports in the individual's socio-cultural environment (such as religion, family, and social supports); 4) *cultural features of the relationship between the individual and the clinician*, such as dynamics of differences based on cultural, socio-economic, language, and social status that may cause differences in communication and influence diagnosis and

treatment; and 5) *overall cultural assessment* summarizing the implications of the above aspects for diagnosis, plan of care, and other clinically relevant issues.⁹

DSM5 also includes a Cultural Formulation Interview (CFI) with suggested questions to assess socio-cultural aspects of psychiatric presentation. The CFI contains four assessment domains: a) cultural definition of the problem; b) cultural perceptions of cause, context, and support; c) cultural factors affecting self-coping and past help-seeking; and d) cultural factors affecting current help-seeking.⁹

Incorporating Cultural Understanding into Clinical Conceptualization and Reports:

There are many ways that a CAP can apply specific cultural understanding of a diverse youth and family into a clinical conceptualization and a formal report. Cultural information may be relevant to and incorporated into each evaluation domain. This is especially the case given that culture for a youth and family is a dynamic, developmental process and the CAP is interested in development. For example, the family's experience of its culture changes with each generation, with migration, with resettlement, and with subsequent moves within the same country. Each of these events creates new challenges to the family's traditional culture and new opportunities to effectively integrate the old and the new. The CAP cannot begin to understand a youth's symptoms or diagnosis without first viewing the youth through the broader lens of his or cultural context.

In writing a report, the CAP can capture some of the cultural complexity and richness of the youth and family with the choice of descriptors used in the Identifying Information. Furthermore, information about migration, refugee trauma, and the challenges of being a member of a minority culture or group is often relevant to the History of Present Illness and to the Family History. Information about challenges and coping, and about acculturation, can be relevant to a discussion of the youth's place in the community and his or her relationship with peers. If there is a language barrier or other culturally relevant elements (such as an immigrant youth having been denied schooling in the country of origin), this information may be relevant to a discussion of the youth's academic functioning and adaptation to school. Furthermore, a youth's cultural heritage, traditions and rituals may be relevant to a discussion of youth and family strengths. Ultimately, the Formulation, Discussion or Hypothesis, depending on the term used in the specific evaluation protocol, offers an opportunity to integrate cultural perspectives into the overall biopsychosocial understanding of the youth and family.

Whether the CAP chooses to compose a separate cultural formulation or instead incorporates relevant cultural issues into the Formulation, Discussion or Hypothesis of the traditional report, the abovementioned outline provides a useful point of reference for organizing one's thoughts about cultural considerations for a particular youth and family. It is also important to appreciate that cultural considerations apply to every youth and family, not just those who have migrated and resettled in a new country or those belonging to a minority group. Therefore, an understanding of culture and its impact on the youth and family, and the inclusion of cultural considerations in written reports, are important components of sound clinical practice. Specific cultural considerations for clinical inquiry and inclusion in the medical record have recently been summarized.⁸

Treatment interventions:

It is highly recommended that the treating clinician utilize evidence-based psychological and pharmacologic interventions that have been researched in the specific ethnic and racial groups. In the recent years there is growing literature on the efficacy of various types of interventions in ethnic minority populations, including: cognitive behavioral therapy for treatment of depression in Latinos and African-Americans,^{10,11} interpersonal psychotherapy for treatment of depression in Latinos¹¹, cognitive behavioral therapy for treatment of anxiety disorders in Latinos¹², group cognitive behavioral therapy for anxiety disorders in African-Americans¹³, trauma-focused cognitive psychotherapy and peer-mediated treatment for traumatic stress for African-Americans¹⁴, and manualized family therapy for the treatment of substance abuse for Latinos.¹⁵

The CAP should also consider ethnopharmacologic factors which may influence a minority youth's response to or experience of side effects to certain medications. The validity and generalizability of current meta-analytic reviews on ethnic differences to drugs tolerability are limited by the small number of participants from ethnically diverse populations. There is a need for future randomized controlled trials to recruit adequate numbers of participants from diverse populations. There is also need for more pharmacogenomic studies which assess gene-by-environment interactions. While such topics are being researched, the CAP should use caution in prescribing and dosing psychotropic medications for diverse populations and base clinical decisions on individual and familial clinical history, ancestral history, migration, and dietary history.

The CAP should also utilize culturally adapted behavioral management techniques. Satisfaction and adherence can be increased by utilizing behavioral management strategies which are in accordance with the youth and family's cultural values and beliefs. Involvement of the immediate and extended family and sometimes non-kinship community members (religious support) is an essential part of treatment planning to achieve positive treatment outcomes including adherence. It is also the clinician's responsibility to assess and educate the families about otherwise culturally sanctioned practices which are illegal or incongruent with the American culture, such as corporal punishment.

Keeping it in the community:

Whenever possible the CAP should treat culturally diverse children and youth in treatment settings within their communities. Examples include schools or community-based clinics in ethnic neighborhoods. Home and community based interventions including school based services are largely preferred over out of home placements and hospitalizations.^{2, 16} In addition, utilizing community and cultural strengths to facilitate effective interventions with diverse children and youth, reinforcing adaptive cultural values and beliefs is recommended.

Access to care and help-seeking behaviors:

Previous studies show that minority families are less likely to seek mental health care and remain engaged in treatment.¹⁷⁻¹⁹ Multiple systemic and logistical barriers that interfere with timely access to services are disproportionately experienced by racially/ethnically diverse families. These barriers to care include financial needs, socio-economic, location of services and transportation, lack of adequate insurance, poorly understood bureaucratic procedures, lack of linguistic support², and stigma. It is important to recognize that many cultural attitudes and beliefs serve as barriers to mental health help-seeking. This includes but is not limited to, perceptions of mental illness (including stigma and beliefs about causality), fatalism, and spirituality. Other barriers include families in which the family is considered the primary unit of

identification and allegiance, which leads to keeping problems within the family, cultural commitment (e.g., to using only culturally sanctioned helping approaches), and language proficiency. It is also noteworthy that after controlling for socio-economic status, a disproportionate number of ethnic minority children are referred through the school, social services and the juvenile justice systems.²⁰

Familiarity with legislative and policy decisions:

On a legislative level, the states of Washington, California, Connecticut, New Jersey and New Mexico mandate cultural competency training for all healthcare providers.²¹ The Affordable Care Act provides for healthcare provider education to improve cultural competency and reduce healthcare disparities.²² The Joint Commission has developed a “Roadmap for Hospitals” to promote effective communication, cultural competence, and patient- and family-centered care to meet the new patient-centered communication standards.²³

V. CHALLENGES AND CONSEQUENCES RELATED TO CULTURE

Disparities:

Disparities involving differential exposure to adverse risk factors, differential prevalence of disorders, lack of culturally competent services resulting in ineffective diagnostic assessment, lack of access to health care and other resources, as well as the over-representation of minority cultures within restrictive child-serving systems (e.g. juvenile justice and child welfare) are pervasive challenges that negatively impact the development and functioning of at risk youth and their families.

Previous studies indicate that five of the ten leading causes of death for low income and minority youth have behavioral health components – e.g., accidents, AIDS, substance abuse, suicide, and homicide. The under-utilization of mental health services by individuals and families from culturally diverse groups makes up a large component of disparities. Several studies in child and adolescent mental health have demonstrated diagnostic biases^{24,25} and significantly lower utilization of mental health services²⁶⁻²⁸ among diverse children and youth. The Surgeon General’s report on “Mental Health: Culture, Race and Ethnicity” documents disparities in health and mental health care for low income and ethnic minority youth and their families.²⁹ Studies have identified four main sources of ethnic health disparities: 1) exposure to environmental, economic, or social conditions that impact disease incidence; 2) clinician bias as a result of lack of culturally competent training or ability so as to implement valid and effective diagnostic assessment or treatment planning; 3) lack of access to, and or lack of availability of preventive services and indicated levels of care, despite individual recognition of need; and 4) the poor quality of care received.²⁹ Other studies also point out the lack of evidence-base available for the effectiveness of usual treatment interventions with minority populations. However, a growing body of work points to the effectiveness of many evidence-based practices with minority children, youth, and families, especially many community-based interventions.³⁰

Over-representation of ethnic minority youth within juvenile justice is well documented nationally and in many states and communities. In the 1990s, advocacy groups, researchers, state and national juvenile justice system representatives and legislators began documenting the

reality of disproportionate minority confinement in the juvenile justice system. In June 2003, a federal law was passed (Juvenile Justice and Delinquency Prevention Act), requiring states to identify the extent to which minorities are over-represented in their juvenile justice systems, determine the reasons for that over-representation, and take steps to reduce it. At the same time, various studies point not only to continued significant over-representation of minorities in the juvenile justice system, but also point to a link between such over-representation and disparities in assessment and access to mental health services.³⁰

In 2003, a national study entitled, “Children of Color in the Child Welfare System: Perspectives from the Child Welfare Community,” explored the attitudes and perceptions of the child welfare community regarding racial disproportionality.³¹ This strengths-based, qualitative study involved site visits to nine child welfare agencies across the country involved in implementing a strategy, practice, or initiative to address racial disproportionality and better meet the needs of families of color. During interviews, agency administrators, supervisors and caseworkers offered hypotheses regarding the over-representation of children of color in the child welfare and juvenile justice systems. These hypotheses included the impact of poverty, differential reporting of abuse and neglect involving minority vs. majority caregivers, over-burdened public systems unable to provide early intervention, and lack of staff experience with minority cultures.

For the CAP, recognition of health care disparities can reinforce a determination to advocate for the needs of poor and minority populations. It can also serve to reinforce a commitment to learn about different cultures and develop effective ways to engage minority youth and their families and to deliver effective, evidence-based, culturally competent treatment and services. The CAP should also be aware that health care disparities and lack of culturally appropriate care can be reduced within primary care through use of care settings that provide what is referred to as “a medical home” for the child and family, where an integrated team of caregivers are better able to gather important information and engage in outreach to the community.

Conflicts between Families and Service Providers:

Families from other cultures may have views about health and mental health that differ from those within the dominant culture. For example, Southeast Asian families may not accept the existence of mental illness and instead regard behavioral disturbance as due to the presence of spirits in the person and punishment for the transgressions of a previous life. CAPs need to understand explanatory models of illness inherent within different cultures and serve as a “bridge” between these models and dominant Western models and beliefs, while demonstrating respect for the family’s values and beliefs. Collaboration with native healers and cultural mediators or brokers can aide in establishing the therapeutic alliance and helping families engage in a treatment relationship. Tailoring care to meet the values of families is essential. The challenge of respecting the values of other cultures at odds with those of mainstream American medicine is beautifully chronicled in the book, *The Spirit Catches You and You Fall Down*.³²

Another type of conflict occurs when a family views all social service professionals indiscriminately as being the same. Families who are subject to what appear to be arbitrary decisions made by social service agencies at times develop a mistrust of the entire system over time. This guarded perspective can in effect become part of the family’s culture. For example, a family may view a CAP as closely allied with a child protection worker and fear that the CAP

will seek to remove a child from the family. This view of the CAP would be consistent with the family's perception of the child protection worker despite the CAP playing a very different role in the child's life. Addressing such a situation would ideally occur at two levels. The CAP and child protection worker should independently and separately establish trust with the family. Each individual should help the family understand that neither professional views removal of the child as a desired or optimal outcome.

Culture can also govern parenting practices that may be at odds with those sanctioned by dominant culture values, beliefs and legal statutes, such as the use of corporal punishment. CAPs need to educate diverse families about dominant cultural values and legal implications, while advocating for an educational rather than punitive approach in assisting diverse minority families in making this transition. Professional "parent partners," i.e. caregivers of youth with complex mental health needs, who represent the diversity of their local communities, can be extremely helpful in supporting families from minority cultures to engage with mental health and other child-serving systems.

The organizational values and biases of provider agencies and disciplines (based on the dominant culture's values and beliefs) may be in conflict with the culture of the family, creating a barrier to the family's receiving optimal health care. Biases are often a subconscious process. Biases and stereotypes on race and ethnicity can lead to unequal treatment. Cultural blindness, motivated by good intentions but nevertheless minimizing the importance of cultural differences and the need for cultural competence, can result in services that do not address critical family priorities. Limited progress or lack of retention in treatment may follow. CAPS should be aware of that cultural biases may interfere with their clinical judgment and work systems should work towards addressing these biases.

V. CONCLUSION

Cultural competency is a developmental process that requires lifelong learning. Learning to be culturally competent enriches us with many opportunities to learn about 1) ourselves 2) children, youth, and families 3) engaging and empowering youth and families 4) child serving systems 5) legislative policies, and 6) provide culturally competent evidence based services.

Given the importance of cultural competence and its multi-level domains, the CAP needs to make the pursuit of cultural competence a high priority. There are various aspects of cultural competency which includes a culturally informed history and formulation, assessing migration-related stressors, recommending evidence based treatments and interventions and understanding pharmacogenomics differences. This includes familiarity with the demographics and population trends along such dimensions as ethnicity and racial mix, languages spoken, socioeconomic status, differing needs among rural, suburban and urban populations, and various religious and spiritual beliefs. It is also important to understand the historical background of each of these populations, including: migration and immigration history; history of traumas, oppression and discrimination; and history of resiliency factors and adaptation traditions and practices. In turn, the CAP should also strive to understand the values, mandates, and practices of the mental health system and other child-serving systems, which guide representatives of various child-serving systems and disciplines.

From a systems perspective, it is of utmost importance to practice community-based interventions and be aware of cultural, linguistic and systems based barriers to seeking care. By embracing cultural competence, the CAP can more effectively serve as a bridge between their culturally diverse patients, families and agencies in the broader system of care. They can also experience more respectful, mutually satisfying intra-professional and cross-system relationships, and youth and families served will benefit from the ensuing collaboration.

APPENDIX 1*

Residents must 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. Residents are expected to:

IV.B.1.f) Systems-based Practice. Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

* Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry.

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277. July 1, 2019.

REFERENCES

1. Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277. July 1, 2019.
2. Practice parameter for cultural competence in child and adolescent psychiatric practice http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Cultural_Competence_Web.pdf. Accessed February 24, 2014.
3. Cross T, Bazron B, Dennis K, Isaacs M. *Towards a Culturally Competent System of Care, Volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center; 1989.
4. Rothe EM, Lewis J, Castillo-Matos H, Martinez O, Busquets R, Martinez I. Post traumatic stress disorder in Cuban children and adolescents after release from a refugee camp. *Psychiatric Services*. 2002; 53:970-976.
5. Pumariega AJ, Rothe EM. Leaving no children or families outside: the challenges of immigration. *Am J Orthopsychiatry* 2010;80:506-516.
6. Suarez-Orozco C, Suarez-Orozco M. *Children and Immigration*. Cambridge, MA: Harvard University Press; 2001.
7. Ho MK. *Minority Children and Adolescents in Therapy*. Thousand Oaks, CA: Sage Publications; 1992.
8. Pumariega A, Rothe E, Rogers K. Cultural competence in child psychiatric practice. *J Am Acad Child and Adolesc Psychiatry*. 2009;48(4):362-366.
9. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 5th edition (DSM 5). Washington: American Psychiatric Association; 2013.
10. Huey S, Polo A. Evidence-based psychosocial treatments for ethnic minority youth. *J Clin Child Adol Psychol*. 2008;37:262–301.
11. Pumariega AJ, Rothe EM, Rogers KM. Depression in immigrant and minority children. In: J M Rey & J Birmaher (Eds.), *Treating Childhood Depression*. New York: Lippincott, Williams and Wilkins, 2008.
12. Pina A, Wendy M, Silverman K, Fuentes R, Kurtines W, Weems C. Exposure-based cognitive-behavioral treatment for phobic and anxiety disorders: Treatment effects and maintenance for Hispanic/Latino relative to European-American youths. *J Am Acad Child Adolesc Psychiatry*. 2003; 42:1179-1187.
13. Ginsburg GS, Drake KL. School-based treatment for anxious African Americans adolescents: A controlled pilot study. *J Am Acad Child Adolesc Psychiatry*. 2002; 41:768–775.
14. Cohen JA, Deblinger E, Mannarino AP, Steer RA. A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *J Am Acad Child Adolesc Psychiatry*. 2004; 43:393–402.
15. Santisteban DA, Coatsworth JD, Perez-Vidal A, et al. Efficacy of brief strategic family therapy in modifying Hispanic adolescent behavior problems and substance use. *J Fam Psychol*. 2003; 17:121–133.
16. Akutsu PD, Castillo ED, Snowden LR. Differential referral patterns to ethnic-specific and mainstream mental health programs for four Asian American groups. *Am J Orthopsychiatry*. 2007; 77:95-103.
17. Angold A, Erkanli A, Farmer E, et al. Psychiatric disorder, impairment, and service use in rural African-American and white youth. *Arch Gen Psychiatry*. 2002;59(10):893-901.

18. Cuffe S, Waller J, Cuccaro M, Pumariega A. Race and gender differences in the treatment of psychiatric disorders in young adolescents. *J Am Acad Child Adolesc Psychiatry*. 1995;34(11):1536-43.
19. Pumariega A, Glover S, Holzer C, Nguyen N. Utilization of mental health services in a tri-ethnic sample of adolescents. *Comm Mental Health J*. 1998;34(2):145-156.
20. Snowden L, Yamada A. Cultural differences in access to care. *Annu Rev Clin Psychol*. 2005;1:143-66.
21. United States. Department of Health & Human Services. Office of Minority Health. *CLAS Legislation Map*. <https://www.thinkculturalhealth.hhs.gov/Content/LegislatiingCLAS.asp>
22. Andrulis D, Siddiqui N, Purtle J, Duchon L Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations 2010 <http://www.jointcenter.org/research/patient-protection-and-affordable-care-act-of-2010-advancing-health-equity-for-racially-and> Accessed December 9, 2013.
23. The Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: The Joint Commission, 2010. Accessed December 9, 2013.
24. Hong V, Pumariega A, Licata C. Race, minority status, cultural isolation, and psychiatric diagnosis in children in public mental health. In: *14th Annual Research Conference, A System of Care for Children's Mental Health Conference Proceedings*. Tampa, FL: Research and Training Center for Children's Mental Health; 2002.
25. Kilgus M, Pumariega A, Cuffe S. Race and diagnosis in adolescent psychiatric inpatients. *J Am Acad Child Adol Psychiatry*. 1995;34(1):67-72.
26. Cuffe S, Waller J, Cuccaro M, Pumariega A, Garrison C. Race and gender differences in the treatment of psychiatric disorders in young adolescents. *J Am Acad Child Adol Psychiatry*. 1995;34(11):1536-1543.
27. Hough R, Hazen A, Soriano F, Wood P, McCabe K, Yeh M. Mental health care for Latinos: mental health services for Latino adolescents with psychiatric disorders. *Psychiatr Svcs*. 2002;53(12):1556-1562.
28. Pumariega A, Glover S, Holzer C, Nguyen N. Utilization of mental health services in a tri-ethnic sample of adolescents. *Community Ment Health J*. 1998;34(2):145-156
29. Office of the Surgeon General. Mental health: culture, race, and ethnicity. Supplement to mental health: report of the surgeon general. SMA-01-3613. <http://www.ncbi.nlm.nih.gov/books/NBK44243/> Published 2001. Accessed February 24 2014.
30. Pumariega A, Atkins D, Rogers K, et al. Mental health and incarcerated youth. II: service utilization in incarcerated youth. *J Child Fam Stud*. 1999;8(2):205-215.
31. Children's Bureau. Children of color in the child welfare system: perspectives from the child welfare community. <http://www.childwelfare.gov/pubs/otherpubs/children/>. Published 2003. Accessed February 24, 2014.
32. Fadiman A. *When the Spirit Catches You and You Fall Down*. New York, NY: Farrar Straus and Giroux; 1997.

OTHER RESOURCE

Pumariega AJ. Cultural competence in systems of care for children's mental health. In: Pumariega AJ, Winters NC, eds. *Handbook of Community Systems of Care; The New Child & Adolescent Community Psychiatry*. San Francisco, CA: Jossey Bass Publishers; 2003:82-106.

WEB RESOURCES:

- AAP's Culturally Effective Care and Self Assessment Tools
http://www.medicalhomeinfo.org/about/newsletter/spotlight_issues/culturalcompetency.aspx
- Implicit Association Tool
<https://implicit.harvard.edu/implicit/>
- Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile
- <http://www.hrsa.gov/culturalcompetence/healthdlvr.pdf>
- National Center for Cultural Competence - Cultural Competence Health Practitioner Assessment
<https://www4.georgetown.edu/uis/keybridge/keyform/form.cfm?formID=277>
- Practice Parameters in Child Psychiatry
http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters
- Office of Minority Health
- <http://minorityhealth.hhs.gov/>
- Child Welfare League Culture/Diversity
<http://www.cwla.org/programs/culture/default.htm>
- National Research and Training Center (NRTC) Toolkit and Training on Assessing Cultural Competency in Peer-Run Mental Health Programs
<http://www.cmhsrp.uic.edu/nrtc/starcenter.asp>
- National Center for Cultural Competence: Cultural Competence Health Practitioner Assessment (CCHPA)
<http://www11.georgetown.edu/research/gucchd/nccc/features/CCHPA.html>

Cultural Considerations – Discussion Vignette I – Trainee Version

Hop Nygun is a 10 year old Vietnamese male who lives with his parents, maternal grandmother, uncle and three younger sisters in a medium-sized Northeast city, where they have lived since emigrating from Vietnam 5 years ago. His family owns a restaurant, and Hop works in the restaurant every weekend. His family life centers on their family, neighbors, restaurant, temple and the community center. Hop participates in his local community's cultural center. He is active in a martial arts club at the center.

Hop also enjoys soccer and plays on a city league team. Hop and his father went to his scheduled sports physical exam. Hop's exam was within normal limits, except for a number of coin marks on his torso. His pediatrician was concerned about the marks and asked Hop if he was being abused. Hop said his grandmother was treating him to make sure that he didn't end up seeing ghosts. His grandmother was concerned about an incident that happened recently. While their martial arts club was performing at a nursing home, a patient suddenly became ill and died after a failed resuscitation. Hop and his teammates witnessed the event. Hop states that since then he has had bad dreams. He stated his grandmother is also treating some of his teammates who are having bad dreams before the cultural center's weekly community dinner. Hop asks the physician not to tell his coach about his grandmother's cures, because cures are old fashioned and "I'm really just American." The pediatrician states that he needs to talk to Hop's parents and grandmother. Hop informs the pediatrician that his sister and he typically translate for his parents. He notes his grandmother and uncle do not speak any English at all. Hop offers to translate for his father today at the visit.

Hop's pediatrician contacts you, the child psychiatrist, for a consultation, because he is concerned Hop has PTSD, and is concerned that the treatments his grandmother is giving could exacerbate the effects of previous trauma. The pediatrician states that he isn't very familiar with Hop's culture and doesn't want to offend anyone but he is mandated to report abuse. Hop doesn't seem to be a victim of child abuse, but he worries about "the coin treatment." The pediatrician tells you he works at a nearby Latino Health Center and generally feels comfortable interacting with families from the Latino culture. He asks you to help him think about a plan of action for Hop and his family.

1. How are the cultural factors interfacing with the health concerns that the pediatrician raises?
2. How would you advise the pediatrician to involve the family including the grandmother to assess their perspective?
3. What challenges does Hop face as he navigates two different cultural systems (Vietnamese and American)?
4. What are the cultural perspectives when it comes to identifying and reporting "coining" as possible abuse?

Cultural Considerations Discussion Vignette II – Trainee Version

Roberto's primary care provider stops you at the library entrance. She is not sure how to set up a meeting with Roberto's parents to discuss Roberto's health status and his preschool teacher's concerns.

Roberto is a four year old Mexican American male who has been living with his mother, father, maternal grandmother and 10 year old half-brother in a Midwestern city. His preschool teacher has requested that the family have Roberto see a doctor. She told the family he needs medication because he doesn't follow directions. She told his father that she is concerned and thinks that Roberto has ADHD. A month passes and the teacher enlists the director of the preschool to suspend Roberto from class until he sees a physician.

Your colleague has an initial evaluation session with Roberto. His grandmother and mother were present. His mother informs you that she and Roberto's father both work full time and Roberto's monolingual (Spanish speaking) grandmother provides most of the child care. He tends to play in the basement where his father is building a workroom in their pre-World War II home. Roberto also plays in the field located between two abandoned houses across the street. Roberto has been taking a "tonic" from his grandmother's cuendero (traditional spiritual healer). His mother stated the tonic makes boys strong.

Prior to starting methylphenidate, the PCP did a physical exam. Laboratory studies were drawn and Roberto was found to have a higher than normal lead level. His physical exam was notable for moderate asthma. The family doctor reported his lead level to the public health department and started chelation therapy. The PCP is aware that a number of traditional healers add minerals and plants to children's tonics. She is frustrated that no one in the Hispanic community has "outlawed" use of herbal preparations like these, because of the health information that is available for patients in the clinic where the family doctor practices. She is also upset that his family lets Roberto play in unsafe areas.

How would you help guide the pediatrician in approaching the symptoms of ADHD in a culturally sensitive manner?