21st Century Culturally & Linguistically Responsive Mental Health Care:

Building a more culturally responsive mental health system for EMPS children, families and professionals

Cecilia Frometa Singh, Ph.D.

Yale University School of Medicine
Child Study Center
7/16/18
When Mexico is sending its people, they’re not sending their best... They’re bringing drugs. They’re bringing crime. They’re rapists. And some, I assume are good people.”

Donald Trump
June 16, 2015

Laura Buckman/Getty Images
I have a great relationship with the blacks. I've always had a great relationship with the blacks.

— Donald Trump

AZ QUOTES

EMPS is a program funded by the State of Connecticut in partnership with the United Way of Connecticut 2-1-1.
Overview of Today

Part 1: Review of Culture, Statistics and Current Affairs

Part 2: Self-Reflection/examination of our own biases

Part 3: Parental/Familial Engagement

Part 4: Theoretical application/underpinnings

Racial Identity Development Review

Part 5: Integrating culturally specific strategies into our work
My Training Approach:
Qualitative and Quantitative Data

- Data/Research on culture and mental health practices from field
- Current affairs
- Clinical case examples
- Your own experiences and thoughts
Disclaimers:

- Conversations are difficult to have (stepping out of our comfort zone)

- My biases: Culture IS important in working with diverse populations, need to consider entire system when working with child and families
Culture Matters

- https://www.youtube.com/watch?v=VrYmQDiunSc
- https://www.youtube.com/watch?v=lrKRm6KAzfU
Disclaimers (continued)

- Portions of day may call for self-disclosure: ‘Okay to say no’

- Objective is simply to help you think critically not to ‘convince’ you to do something differently

- Many more trainings/support needed (multiple levels)
Difficult Dialogues are a Crucial Part of The Process

Conversations about race, trauma, disproportionality, and equity are *awkward and often difficult*, but necessary.
Review of CT Statistics

WHY ARE WE TALKING ABOUT THIS?
Why Culture Is Important

• The dramatic change in our nation’s ethnic composition is altering the way we think about ourselves

• Culture influences most, if not all, aspects of human social interactions
Over 70% of African American adolescents with a major depressive episode did not receive treatment for their condition.

Almost 25% of adolescents with a major depressive episode in the last year were Hispanic.

Asian American adults were less likely to use mental health services than any other racial/ethnic groups.

In the past year, nearly 1 in 10 American Indian or Alaska Native young adults had serious thoughts of suicide.

In the past year, 1 in 7 Native Hawaiian and Pacific Islander adults had a diagnosable mental illness.

July is National Minority Mental Health Month.

Get involved in reducing behavioral health disparities in diverse communities and join the #MMHM2015 conversation on Twitter.

For more information about behavioral health and diverse populations, visit samhsa.gov/obhe.

SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.
EMERGENCY MOBILE PSYCHIATRIC SERVICES

EMPS is a program funded by the State of Connecticut in partnership with the United Way of Connecticut 2-1-1.

Latino adults with mental illness are less likely to receive treatment or counseling*

*Compared to non-Hispanic whites
Source: SAMHSA, 2014

#GETCOVERED

FamiliesUSA.org
Racial Disparities in Mental Health Treatment

31% of white children with mental health problems receive mental health services.

Only 13% of children from diverse racial and ethnic backgrounds with mental health problems receive mental health services.

Source: National Center for Children in Poverty
Racial Disparities in Mental Health Treatment

Of white health care providers,

51% believe that their patients do not adhere to medical treatments as a result of cultural or linguistic barriers.

56% report having no form of cultural competency training.

Source: National Alliance on Mental Illness
Connecticut Stats

- 12.9% (452,358 persons) of Connecticut’s residents were born outside of the US

- Increase of 61% in the size of Connecticut’s foreign-born population since 1990 and a growth of 21% since 2000.

- Connecticut has the 11th highest percentage of foreign-born residents in the country.

- Connecticut has the largest proportion of residents born in Puerto Rico
Where immigrants live in CT

- Clustering- often choosing to live near others from the same home country
- Three of Connecticut’s eight counties have attracted 87% of Connecticut’s foreign-born population –
  - Fairfield County: 39% of the state’s foreign-born residents;
  - Hartford County: 28% of foreign-born residents
  - New Haven County: 20% of foreign-born residents
- Further, Fairfield County has also attracted the largest Latino-American population with 60% of CT’s immigrants from Latin America residing there.
Brief review of CT immigration statistics

- About **one out of every eight** residents living in Connecticut was born outside the United States.

- There is an increase in CT immigrant population from **one in nine residents** at the time of the 2000 census and one in eleven at the time of the 1990 census.
Between 1995 and 2025:

- CT is expected to gain 337,000 people through international migration
- Doubling the foreign-born population (the 12th greatest percentage increase in immigrant population size among the fifty states)
- Trump: would decrease immigration by up to 500k new immigrants with stricter laws (family sponsorship, selected groups)
### 100 years of immigration to the US

<table>
<thead>
<tr>
<th>Decade</th>
<th>Number of Immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900s</td>
<td>8,202,388</td>
</tr>
<tr>
<td>1910s</td>
<td>6,347,380</td>
</tr>
<tr>
<td>1920s</td>
<td>4,295,510</td>
</tr>
<tr>
<td>1930s</td>
<td>699,375</td>
</tr>
<tr>
<td>1940s</td>
<td>856,608</td>
</tr>
<tr>
<td>1950s</td>
<td>2,499,268</td>
</tr>
<tr>
<td>1960s</td>
<td>3,213,749</td>
</tr>
<tr>
<td>1970s</td>
<td>4,248,203</td>
</tr>
<tr>
<td>1980s</td>
<td>6,244,379</td>
</tr>
<tr>
<td>1990s</td>
<td>9,775,398</td>
</tr>
<tr>
<td>2000s</td>
<td>10,299,430</td>
</tr>
</tbody>
</table>

Source: 2015 Yearbook of Immigration Statistics, Department of Homeland Security
### Jobs most likely to be filled by an immigrant

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Undocumented immigrants</th>
<th>Lawful immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal appearance workers</td>
<td>12%</td>
<td>51%</td>
</tr>
<tr>
<td>Graders, sorters of agricultural products</td>
<td>28%</td>
<td>32%</td>
</tr>
<tr>
<td>Plasterers and stucco masons</td>
<td>36%</td>
<td>23%</td>
</tr>
<tr>
<td>Sewing machine operators</td>
<td>23%</td>
<td>32%</td>
</tr>
<tr>
<td>Agricultural workers</td>
<td>30%</td>
<td>21%</td>
</tr>
<tr>
<td>Maids and housekeeping cleaners</td>
<td>24%</td>
<td>26%</td>
</tr>
<tr>
<td>Tailors, dressmakers, sewers</td>
<td>11%</td>
<td>39%</td>
</tr>
<tr>
<td>Drywall and ceiling tile installers, tapers</td>
<td>31%</td>
<td>17%</td>
</tr>
<tr>
<td>Taxi drivers and chauffeurs</td>
<td>7%</td>
<td>40%</td>
</tr>
<tr>
<td>Media and communication workers</td>
<td>5%</td>
<td>40%</td>
</tr>
</tbody>
</table>


Source: Pew Research Center Estimates
The immigrant workforce in the U.S.

82.9%
Native-born workers

12.1%
Immigrants authorized to work in the U.S.

5%
Undocumented immigrants*

Note: Roughly 10% of undocumented immigrants have been granted temporary protection from deportation and are eligible to work under two federal programs.
Source: Pew Research Center
## Jobs most likely to be filled by an immigrant

<table>
<thead>
<tr>
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<tr>
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<td>Drywall and ceiling tile installers, tapers</td>
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<td>17</td>
</tr>
<tr>
<td>Taxi drivers and chauffeurs</td>
<td>7</td>
<td>40</td>
</tr>
<tr>
<td>Media and communication workers</td>
<td>5</td>
<td>40</td>
</tr>
</tbody>
</table>

Wo die "Dreamers" herkommen
Migranten nach Herkunft, die im Rahmen des DACA-Programms in den USA leben*

<table>
<thead>
<tr>
<th>Land</th>
<th>Anzahl</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexiko</td>
<td>618.342</td>
</tr>
<tr>
<td>El Salvador</td>
<td>28.371</td>
</tr>
<tr>
<td>Guatemala</td>
<td>19.792</td>
</tr>
<tr>
<td>Honduras</td>
<td>18.262</td>
</tr>
<tr>
<td>Peru</td>
<td>9.066</td>
</tr>
<tr>
<td>Brasilien</td>
<td>7.361</td>
</tr>
<tr>
<td>Südkorea</td>
<td>7.250</td>
</tr>
<tr>
<td>Ecuador</td>
<td>6.696</td>
</tr>
<tr>
<td>Kolumbien</td>
<td>6.591</td>
</tr>
<tr>
<td>Philippinen</td>
<td>4.655</td>
</tr>
</tbody>
</table>

Deferred Action for Childhood Arrivals (DACA): Schutzprogramm für junge Migranten ohne Papiere
* Genehmigte Erstbewerbungen von August 2012 (Start des Programms) bis 31. März 2017

Quelle: U.S. Citizenship and Immigration Services
EMERGENCY MOBILE PSYCHIATRIC SERVICES

NATIONAL STATISTICS

1 IN 6 BOYS
1 IN 4 GIRLS
WILL HAVE EXPERIENCED AN EPISODE
OF SEXUAL ABUSE BY AGE 18

1 OF 3 ABUSED AND NEGLECTED CHILDREN
MAY LATER ABUSE THEIR OWN CHILDREN

A REPORT OF CHILD ABUSE IS MADE EVERY 10 SECONDS

CONNECTICUT STATISTICS

70% OF CLIFFORD BEERS CLINIC OUTPATIENT CLIENTS REPORT AT LEAST 1 TRAUMA

UP TO 80% OF CHILDREN IN JUVENILE JUSTICE SYSTEM SCREEN POSITIVE FOR TRAUMA EXPOSURE

90% OF PUBLIC MENTAL HEALTH CLIENTS HAVE BEEN EXPOSED TO TRAUMA

Rate of victimization of youth (per 1000 youth)

<table>
<thead>
<tr>
<th>Rate</th>
<th>National rate</th>
<th>CT rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>National rate</td>
<td>9.5</td>
<td></td>
</tr>
<tr>
<td>CT rate</td>
<td>11.0</td>
<td></td>
</tr>
</tbody>
</table>

EMPS is a program funded by the State of Connecticut in partnership with the United Way of Connecticut 2-1-1.
States with the lowest prevalence of mental illness and highest rates of access to care include:

### Prevalence Ranking

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Georgia</td>
</tr>
<tr>
<td>2</td>
<td>New Jersey</td>
</tr>
<tr>
<td>3</td>
<td>Illinois</td>
</tr>
<tr>
<td>4</td>
<td>Minnesota</td>
</tr>
<tr>
<td>5</td>
<td>South Dakota</td>
</tr>
<tr>
<td>6</td>
<td>North Dakota</td>
</tr>
<tr>
<td>7</td>
<td>Florida</td>
</tr>
<tr>
<td>8</td>
<td>Connecticut</td>
</tr>
<tr>
<td>9</td>
<td>Alabama</td>
</tr>
<tr>
<td>10</td>
<td>New York</td>
</tr>
<tr>
<td>11</td>
<td>Mississippi</td>
</tr>
<tr>
<td>12</td>
<td>Kentucky</td>
</tr>
<tr>
<td>13</td>
<td>Maryland</td>
</tr>
<tr>
<td>14</td>
<td>Kansas</td>
</tr>
<tr>
<td>15</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>16</td>
<td>Tennessee</td>
</tr>
<tr>
<td>17</td>
<td>Pennsylvania</td>
</tr>
<tr>
<td>18</td>
<td>Iowa</td>
</tr>
<tr>
<td>19</td>
<td>Texas</td>
</tr>
<tr>
<td>20</td>
<td>Oklahoma</td>
</tr>
<tr>
<td>21</td>
<td>Alaska</td>
</tr>
<tr>
<td>22</td>
<td>Ohio</td>
</tr>
<tr>
<td>23</td>
<td>South Carolina</td>
</tr>
<tr>
<td>24</td>
<td>Nebraska</td>
</tr>
<tr>
<td>25</td>
<td>Nevada</td>
</tr>
<tr>
<td>26</td>
<td>Delaware</td>
</tr>
<tr>
<td>27</td>
<td>California</td>
</tr>
<tr>
<td>28</td>
<td>Missouri</td>
</tr>
<tr>
<td>29</td>
<td>Virginia</td>
</tr>
<tr>
<td>30</td>
<td>Hawaii</td>
</tr>
<tr>
<td>31</td>
<td>Colorado</td>
</tr>
<tr>
<td>32</td>
<td>Louisiana</td>
</tr>
<tr>
<td>33</td>
<td>Arkansas</td>
</tr>
<tr>
<td>34</td>
<td>New Hampshire</td>
</tr>
<tr>
<td>35</td>
<td>North Carolina</td>
</tr>
<tr>
<td>36</td>
<td>Indiana</td>
</tr>
<tr>
<td>37</td>
<td>Idaho</td>
</tr>
<tr>
<td>38</td>
<td>Montana</td>
</tr>
<tr>
<td>39</td>
<td>West Virginia</td>
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<tr>
<td>40</td>
<td>Arizona</td>
</tr>
<tr>
<td>41</td>
<td>DC</td>
</tr>
<tr>
<td>42</td>
<td>Michigan</td>
</tr>
<tr>
<td>43</td>
<td>Utah</td>
</tr>
<tr>
<td>44</td>
<td>New Mexico</td>
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<tr>
<td>45</td>
<td>Vermont</td>
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<tr>
<td>46</td>
<td>Wyoming</td>
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<tr>
<td>47</td>
<td>Wisconsin</td>
</tr>
<tr>
<td>48</td>
<td>Washington</td>
</tr>
<tr>
<td>49</td>
<td>Maine</td>
</tr>
<tr>
<td>50</td>
<td>Rhode Island</td>
</tr>
<tr>
<td>51</td>
<td>Oregon</td>
</tr>
</tbody>
</table>

Source: Mental Health America 2016
Transformation of “whiteness”
Culture

- No universally accepted definition

- Culture has been defined in various ways by different disciplines and for numerous purposes (Kao, Hsu, & Clark, 2004)

- There will probably never be a single definition of culture (Kao et al., 2004)
Ethnicity: How Does It Differ From Race and Culture?
Race and Ethnicity

- Race is a biological term used to describe subspecies of organisms.
- The physical variation in humans, though perhaps seemingly great, is genetically minimal.
- During the history of humanity, populations have never been isolated long enough to become true biological races.

Social races are cultural constructs.
Race and Ethnicity

- An ethnic group may define themselves as different because of their language, religion, geography, history, ancestry, or physical traits.

- An ethnic group that is assumed to have a biological basis is called a race.
Minority Status

- The definitive feature of a minority group is that its members systematically experience lesser income, authority, and power than other members of their society.

- A minority group is not necessarily a smaller population than other groups.
Prejudice and Discrimination

- Prejudice is the devaluation of a given group based upon the assumed characteristics of that group.

- Discrimination is disproportionately harmful treatment of a group, which can be *de jure* or *de facto*.
How Has Culture Been Defined?

- The USDHHS Office of Minority Health (2000) defined culture as:
  
  “integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups” (p. 2).

https://www.youtube.com/watch?v=Me2HlTQPS40
An individual can identify with multiple groups

- Nationality
- Class
- Religion
- Race
- Gender
- Family
- Age
- Education
- Ethnicity
- Geography
- Ability
- Profession
- Sexual Orientation
Gender Related Issues and Risk

- https://www.youtube.com/watch?v=hmDLu-2ZsLI
Culture

- Sadly, relatively high levels of severity of a mental health problem are required in order for culturally diverse individuals to overcome their reluctance to seek help from a professional
High Need Populations

- Overrepresentation of ethnically diverse populations
  - Homeless
  - Chronic Disease and Disability
  - Correctional facilities
  - Victims of violence
  - Child welfare
Culture and Mental Health

- Culture plays pivotal roles in mental health, mental illness, and mental health services

- Understanding the wide-ranging roles of culture enables us to deliver and design services that are more responsive to the needs of culturally and linguistically diverse individuals
Examples of Disparities in Mental Health

African Americans

- Less likely to seek treatment
- When they do seek treatment, they are more likely to use the emergency room for mental health care, and they are more likely than whites to receive inpatient care

Examples of Disparities in Mental Health

Latinos/Hispanic Americans

- In a national survey of high school students, Hispanic adolescents reported more suicidal ideation and attempts than whites and blacks.

- Studies also show that Latino youth experience more anxiety-related and delinquency problem behaviors, depression, and drug use than do white youth.

Examples of Disparities in Mental Health
Asian Americans/Pacific Islanders

- Only 25 percent as likely as whites and 50 percent likely as African Americans and Latinos to seek outpatient care

- Less likely than whites to receive inpatient care

- When they do seek care, they are more likely to be misdiagnosed as "problem-free"

Examples of Disparities in Mental Health

American Indians/Alaska Natives

- Appear to suffer disproportionately from depression and substance abuse
- Overly represented in in-patient care as compared to whites, with the exception of private psychiatric hospitals
- The prevalence rate of suicide is 1.5 times the national rate. Males ages 15 to 24 account for 2/3 of all AI/AN suicides

Mental Health Disparities: Non-Majority Cultures

- Less access to receive bi-lingual services
- More likely to be misdiagnosed
- Less evidence based care
- More inpatient hospitalizations
- Less follow up after psychiatric hospitalization

Cultural Competence Standards, 1997
Mental Health Disparities

- Under-diagnosis and under-treatment of anxiety and mood disorders
- Differential prescribing patterns
- Lower metabolism of certain psychotropic medications
- More side effects and less adherence
- More seclusion and restraint
Current Affairs - The Changing of America

Special Issue

Take a good look at this woman. She was created by a computer from a mix of several races. What you see is a remarkable preview of...

The New Face of America
How Immigrants Are Shaping the World’s First Multicultural Society
Current Affairs

- https://www.youtube.com/watch?v=XzeQ1vrlpOrk

- https://www.youtube.com/watch?v=0P3rvrtx07o

EMERGENCY MOBILE PSYCHIATRIC SERVICES

EMPS is a program funded by the State of Connecticut in partnership with the United Way of Connecticut 2-1-1.
RACE MURDER IN VIRGINIA: BLACK REPORTER SUSPECTED OF EXECUTING WHITE COLLEAGUES — ON LIVE TELEVISION!

by JOHN NOLTE
SAME-SEX MARRIAGE IS A RIGHT, THE SUPREME COURT RULES, 5-4

Long-Sought Victory for Gay Rights
By ADAM LIPTAK 23 minutes ago
The decision came against the backdrop of fast-moving changes in public opinion, with polls indicating that most Americans now approve of same-sex marriage.

114 Comments

Live Coverage: Reaction to Ruling
The Times is providing updates and analysis on the landmark same-sex marriage decision issued Friday.

The view outside the Supreme Court on Friday. DOUG MILLS/THE NEW YORK TIMES

- Marriage State by State: From a Few to the Nation
- The Roots of Justice Anthony Kennedy’s Tolerance
- Major Supreme Court Cases in 2015
Legalization of same sex marriages
EMPS is a program funded by the State of Connecticut in partnership with the United Way of Connecticut 2-1-1.
Immigrants in the U.S. illegally

Number of undocumented immigrants by state, with percentage of total, 2012

Source: Pew Research Center

Change in undocumented immigrants by state, 2009 to 2012

Percentage of undocumented immigrants in Wisconsin by country of birth

Journal Sentinel
IT'S NOT ABOUT BEING AGAINST IMMIGRANTS!

It's about doing things legally. If I were to come over to your house, I would knock on the FRONT DOOR. I wouldn't walk around your house, crawl in through your bathroom window, and then sneak up behind you and scream, 'FEED ME!' Stop distorting the facts! We're only asking that our government enforce our EXISTING LAWS!

www.facebook.com/OneNationUnderGodUSofA
PART 2: SELF-AWARENESS IN OUR WORK WITH CHILDREN AND FAMILIES

SELF - AWARENESS

YOU

VALUES

Concepts
Reflective
Decisive
Details
 driven

Facts
Ideas

Personality
Expressive

Status
Creativity

Work:life balance
Altruism

Risk
Leadership

Stability

Interests
Travelling
Environment

Music
Biology
Sport

Health

Teamwork
Technical
Problem-solving
Organisational
Motivational
Analytical
Communication
SKILLS
Therapist Self-Awareness

- Therapists should have (or make sure to gain) self awareness of their own values and monitor how their contextual background filters their understanding of a family.

SELF-AWARENESS #1 PRIORITY

N OF 1 (WHERE IT ALL STARTS)
ADDRESSING Diversity
In Ourselves and In Our Clients

- Age-related issues
- Disability of individual
- Disability of caregiver/sibling
- Religious upbringing
- Ethnic identity
- Socioeconomic status
- Sexual orientation
- Indigenous heritage
- National identity
- Gender-related issues
# ADDRESSING Diversity

<table>
<thead>
<tr>
<th>Cultural characteristic</th>
<th>Power</th>
<th>Less power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Adults</td>
<td>Children, adolescents, elders</td>
</tr>
<tr>
<td>Disability</td>
<td>Temporarily able-bodied</td>
<td>Persons with disabilities</td>
</tr>
<tr>
<td>Religion</td>
<td>Christians</td>
<td>Jews, Muslims, other non-Christian</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Euro-American</td>
<td>People of Color</td>
</tr>
<tr>
<td>Social Class</td>
<td>Owning &amp; Middle Class (access to higher ed.)</td>
<td>Poor &amp; Working Class</td>
</tr>
</tbody>
</table>
# ADDRESSING Diversity

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<thead>
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<th>Less power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexuality Orientation</td>
<td>Heterosexuals</td>
<td>Gay men, Lesbians, Bisexuals</td>
</tr>
<tr>
<td>Indigenous Background</td>
<td>Non-native</td>
<td>Native</td>
</tr>
<tr>
<td>National Origin</td>
<td>U.S. born</td>
<td>Immigrants &amp; Refugees</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>Female, Transgendered, Intersexed</td>
</tr>
</tbody>
</table>
Vernā Myers: How to overcome our biases?
Walk boldly toward them

- https://www.ted.com/playlists/250/talks_to_help_you_understand_r
PART 3:
PARENTAL/FAMILY ENGAGEMENT IN TREATMENT
THROUGH A CULTURAL LENS
Children, Parents and Families

“A Parent is a Child’s First Teacher” - Unknown
My First Teacher!
Treatment with Families

- The most effective way to work with individuals is in the context of their families

- Clinical services are most effective when they are delivered to both parents and children
Our Clinical/Cultural Thought Process

- Step I: “What are they (client/s) saying”

- Step II: “What does it mean”

- Step III: “How do you understand it in context of presenting issue and in the context of larger family cultural system”

- Step IV: “How/when do you use it to continue to engage and treat child/family”
Exploring Therapeutic Engagement

- Engagement is essential in all phases of treatment (on-going)

- Therapeutic engagement involves healthcare professionals spending quality time with patients and aims to empower the patient to actively participate in their care (Pereira, 2007).

- The initial therapeutic process that is critical for retaining clients in the treatment and for their becoming therapeutically engaged in the recovery process (Simpson, 2002).
Why is Therapeutic Engagement Important?

- Non-engagement leads to higher drop out rates in treatment
- No change in current individual, parent or familial functioning
- More serious presenting issues
- Impact of family’s view of treatment with future providers
- Other?
Understanding Engagement Challenges

Fear of involvement with child protective services

Beliefs services cannot help based on past experiences

Fear of disclosing violent, illegal, or other such negative activity within the family “secrets”

Reluctance to tell family “business” outside the family circle “disloyalty”
  ● Expectation of rejection or criticism
  ● Not perceiving the services offered as being relevant to their needs “they don’t feel heard”
Engagement and Cultural Considerations

- The meaning of going into a office/having someone come to their homes/call their home

- Help seeking behaviors (medical issues, PDD)

- Timing (present/future focused)

- Patterns of handling emotions
Engagement and Cultural Considerations

- Conflict/communication patterns
- Views of mental health
- Views of family
- Views of child’s role, obligations in relation to gender (case age 7 was equivalent to an adult)
Engagement and Cultural Considerations

- Developmental Milestones (sleeping arrangement, toilet training)

- Discipline Methods

- Peers relationships - what does this represent to this family/how important is this?

- Bottle-feeding
Engagement and Cultural Considerations

- Breastfeeding
- Starting solid foods
- Napping/Sleeping
- Toileting
- Use of comfort items
Stop, Understand and Listen! - The case of J
Group Exercise

Please consult with your colleagues at table: Wanted: 1 Volunteer from each table needed.

Please think of a case that you currently have or have had, are there any elements of engagement challenges that you think were directly impacted by cultural variables.

Please discuss 5-10 minutes then we will have a group discussion based on volunteers.
PART 4: THEORETICAL APPLICATIONS/UNDERPINNINGS: DEVELOPMENTAL CONSIDERATIONS CULTURAL RESPONSIVITY
General Theories and Concepts

- Cultural encapsulation (Wrenn, 1985)
- Emic vs. Etic Orientation
- High- versus Low Context Communication (Hall, 1969)
- Effects of Oppression (Landrum & Batts, 1985)
- Functional vs. Healthy Cultural Paranoia (Ridley, 1984)
General Theories and Concepts

Cultural encapsulation:

When a therapist...

- Defines everyone’s reality according to their own cultural assumptions and stereotypes
- Disregard cultural differences
- Ignore evidence that disconfirms their beliefs
- Rely on techniques and strategies to solve problems
- Disregard their own cultural biases
General Theories and Concepts

Emic vs. Etic Orientation:

- Emic- (culture specific) orientation- attempt is made to see things through the eyes of the members of that culture

- Etic-universal (culture general) orientation- involves viewing people from different cultures as essentially the same
General Theories and Concepts

High- versus Low Context Communication:

- High-context communication - grounded in the situation, depends on group understanding, relies heavily on nonverbal cues, helps unify a culture, and is slow to change.

(characteristic of many culturally-diverse groups in the US)
High- versus Low Context Communication:

- Low-context communication relies primarily on the explicit, verbal part of a message.
- Less unifying than high-context communication and can change rapidly and easily.

(characteristic of Euro-American cultures)
General Theories and Concepts

Functional vs. Healthy Cultural Paranoia:

Non-disclosure by African-American clients in context of:

- **Cultural Paranoia**: Healthy reaction to racism, when non-disclosure to therapist occurs d/t fear of being hurt or misunderstood

- **Functional Paranoia**: When client is unwilling to disclose to any therapist regardless of race or ethnicity d/t general mistrust and suspicion
Critical Issues and Behaviors Affected By Culture

- Patterns of decision making
- Social interaction
- Patterns of handling emotions
- Definition of mental illness
- Theory of disease
- Roles, expectations, obligations, in relation to age, sex, class, kinship
- Language
- Impact of culture on use of treatment modalities
Culture and Treatment

● “Fit” between services provided and cultural beliefs and practices of clients and significant others important in:
  - reducing attrition
  - attaining positive treatment outcome
● Caution: There is diversity within ethnic groups (socioeconomic background, urban/ rural, nationality) to consider.
● Use and awareness of community & cultural resources.
● Explanation of therapy and therapist role (may be unfamiliar).
Culture and Treatment

- Education for client and family.
  - Many ethnic minority families have little knowledge of nature, prognosis, symptoms
  - Many families lack information and skills to provide optimal support and care of loved one (Bae & Kung, 2000).
    - Education reduces self/family blame
    - Reduces family stress
    - Reading level
    - High functioning individuals/family
Culture and Treatment

- Consider Total Client Context
  - Poverty
  - Discrimination
  - Underemployment, poor housing, etc.
  - Some live with alcoholism and substance abuse, crime victimization, domestic violence
Brief Review of Development

Racial Development
Identity Development

- Contributions of Erik Erikson

“Identity development is an extended period of exploration reflection, and observation on the part of an individual in relation to others.”

- Other researchers have concluded that identity is formed through one’s experiences

- Additionally, identity is referred to as an individual’s level of identification within society and the degree of difference that is acknowledged by that individual
Developmental Stages of Racial Identity

The three stages are:

*Recognition* (Who is Black?)

*Perceptual identity* (Who is different from you?)

*Consistency and continuity* (If a Black child has on a blonde wig, are they White or Black?).
Recognition Stage

- A child is able to recognize the difference between White and African American people around age 3 or 4 years.

- African American and White children fully recognize their group only after recognizing group differences.
Perceptual Identity Stage

- Characterized by recognition of the perceptual differences in distinctive ethnic groups, does not emerge until age 4 or 5
- Children in this stage gain the capacity to distinguish between out-group dissimilarities and in-group similarities
- Around age 7, children begin to acknowledge that ethnicity is unchangeable.
Ethnic Consistency Stage

- Does not fully emerge until age 8
- *Continuity* of ethnicity may not develop until somewhat later.
- Many Black children under the age of 10 believe that a Black person would be considered White if they wore light make-up and a blond wig
- By 10 years of age, perceptual identification remains constant, and continuity of ethnicity continues to evolve.
Child Development Dolls

- https://www.youtube.com/watch?v=tkpUyB2xgTM

- Parents response:

- https://www.youtube.com/watch?v=UOVwrcTzRBs
CULTURAL RESPONSIVITY
Cultural Responsivity

A developmental process.

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

Having the capacity to function effectively in cultural contexts that differ from your own.
Cultural Responsivity

Becoming culturally responsive is a developmental process which includes engaging in conversations about race and equity, reflecting on one’s own culture and beliefs, and gaining awareness of other cultures.
Diversity & Cultural Responsivity

Valuing Diversity is a necessary step along the continuum of cultural competency and culturally responsive pedagogy, but it is not enough.

Cultural Responsivity requires knowledge, skills and experience and the ability to transform these into practice which results in improved services and outcomes.
Three key facets of cultural responsivity:

1. An understanding of your cultural identity.
   - What do you value?
   - What is your style of communication?
   - What are your strengths and challenges around teaching and learning? (therapy)
   - What are your expectations?
Three key facets of cultural responsivity:

2. An understanding of your client’s cultural identity.
   - What do they value?
   - What is their style of communication?
   - What are their strengths and challenges around teaching and learning? (therapy)
   - What are their expectations?
Three key facets of cultural responsivity:

3. Understanding what happens when different cultures intersect.

How do you capitalize on cultural capitol?
How do you bridge differences?
How do you create access to opportunities?
Summary Points:

Know your own cultural identity.

Gain an awareness of the cultural identity of your clients and their families.

Form an understanding of what happens when different cultures intersect, and capitalize on the energy of what can happen.
PART 5: INTEGRATING CULTURALLY SPECIFIC STRATEGIES INTO OUR WORK

- Nationality
- Class
- Religion
- Race
- Gender
- Family
- Sexual Orientation
- Age
- Education
- Geography
- Ethnicity
- Ability
- Profession
DSM-5 and Culture
Approach to Clinical Case Formulation

Diagnostic content
✓ Diagnostic Features
✓ Associated Features
✓ Prevalence
✓ Development and Course
✓ Risk and Prognostic Factors
  (Environment, Genetic and physiological, Temperamental, Course modifiers)
✓ Culture-Related Diagnostic Issues
✓ Gender-Related Diagnostic Issue
✓ Suicide Risk

✓ Functional Consequences
✓ Differential Diagnosis
✓ Comorbidity Subtypes
  Specifiers – course, severity, descriptive, In Full/Partial Remission
  Mild/Moderate/Severe/Extreme/Profound, Single/Recurrent/Episodic/ Persistent
  Acute/Subacute, Generalized/Situational, Lifelong/Acquired
Cultural Formulation

- **Outline for Cultural Formulation**
  Identity, conceptualization, psychosocial stressors, therapy relationship, and overall assessment
  - **Cultural Formulation Interview (CFI)**
    In the CFI, culture refers primarily to the values, orientations, and assumptions that individuals derive from membership in diverse social groups (e.g., ethnic groups, the military, faith communities), which may conform or differ from medical explanations
    - Set of 14 questions that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of care
  - Cultural Definition of the Problem - Cultural Perceptions of Cause, Context, and Support - Cultural Factors Affecting Self Coping & Past Help Seeking Current Help Seeking
  - **Cultural Concepts of Distress**
    To avoid misdiagnosis, obtain useful clinical information, improve clinical rapport and engagement, improve therapeutic efficacy, guide clinical research, and clarify cultural epidemiology
ADDRESSING Diversity
In Ourselves and In Our Patients

- Age-related issues
- Disability of individual
- Disability of caregiver/sibling
- Religious upbringing
- Ethnic identity
- Socioeconomic status
- Sexual orientation
- Indigenous heritage
- National identity
- Gender-related issues
Addressing

<table>
<thead>
<tr>
<th>Cultural characteristic</th>
<th>Power</th>
<th>Less power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Adults</td>
<td>Children, adolescents, elders</td>
</tr>
<tr>
<td>Disability</td>
<td>Temporarily able-bodied</td>
<td>Persons with disabilities</td>
</tr>
<tr>
<td>Religion</td>
<td>Christians</td>
<td>Jews, Muslims, other non-Christian</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Euro-American</td>
<td>People of Color</td>
</tr>
</tbody>
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**ADDRESSING: A model of cultural influences and their relationship to the social construct of power**

### ADDRESSING: A model of cultural influences and their relationship to the social construct of power


<table>
<thead>
<tr>
<th>Cultural characteristic</th>
<th>Power</th>
<th>Less power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Class</td>
<td>Owning &amp; Middle Class (access to higher ed.)</td>
<td>Poor &amp; Working Class</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Heterosexuals</td>
<td>Gay men, Lesbians, Bisexuals</td>
</tr>
<tr>
<td>Indigenous Background</td>
<td>Non-native</td>
<td>Native</td>
</tr>
<tr>
<td>National Origin</td>
<td>U.S.born</td>
<td>Immigrants &amp; Refugees</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>Female, Transgendered, Intersexed</td>
</tr>
</tbody>
</table>
An individual can identify with multiple groups

- Nationality
- Race
- Class
- Gender
- Religion
- Family
- Age
- Education
- Ethnicity
- Geography
- Ability
- Profession
- Sexual Orientation
Personal Journey

- Engage in reflective practice
- Explore personal and family histories
- Acknowledge membership in different groups
- Learn about the history and experiences of diverse groups

Gay, Villegas & Lucas, 1997
Our Professional Challenge

Compartmentalizing approach to understanding working with diverse populations (piece meal)

vs.

Dynamic approach to clinical conceptualization
A Framework for Cultural Integration and Conceptualization (Akbar & Singh)

Cognition: Technician Phase
(i.e. intellectualization, theory-focused)
A Framework for Cultural Integration and Conceptualization (Akbar & Singh)

Affect: ‘Being Human’
(i.e. intuition, gut feeling in situations)
A Framework for Cultural Integration and Conceptualization (Akbar & Singh)

Balance: Advanced level clinical Phase:
(i.e. taking data, feeling, theory, integration)
Multicultural Competence: Ideology

Balance

Cognition

Affect
10 year old Latino boy in 4th grade
Parents immigrated to US from Latin American Countries (father sought political asylum, mother South American).
Student Presentation: Socially: Quiet, almost painfully shy, soft spoken but focused and intense. Increasingly withdrawn and began looking disheveled at school. Spontaneously took a pencil one day and stabbed a student. Could not be redirected.
Academic issues: Student excelling academically until this incident.
Parents: working poor class (father truck driver, mother factory worker- also taking ESL classes)
EMPS Referral: For increase aggression, out of character behavior, inability to engage parents at school
Guiding Questions

Guiding questions:
- What do you think you would tackle first in this case?
- What are your thoughts about working with the parents?
- How do you think your own background would influence what lens you would use to assess and treat this case?
- What is your cultural conceptualization of this case?
Principles of Culturally Competent Intervention
Continuum of Addressing Diversity

- Cultural Sensitivity
- Cultural Competence/Responsiveness
- Cultural Specificity
Culturally Competent Practices

Eight practices based on strategies developed by Bernal, et al. (1995) to promote culturally competent interactions. The principles are designed to be measurable by an objective rater.

1. Use language that enhances comfort and understanding. Avoid use of jargon or “loaded terminology.”
Culturally Competent Practices

2. Acknowledge and use similarities and differences between individuals to shape and enhance the relationship.

Culture is a central aspect of our assessment and intervention. The therapist’s culture as it relates to the process of engagement, clinical effectiveness and retention in treatment must be included early in the therapeutic process.

Clients must be given an opportunity to discuss their feelings about the therapist’s culture (race, gender, SES, etc.). When clients are uncomfortable in even discussing differences or similarities, the therapist will raise and test hypotheses about his/her cultural impact with supervisors and colleagues.
Culturally Competent Practices

3. Encourage ethnic/cultural symbols, concepts, sayings, stories as part of the dialogue.

The therapist who has genuine knowledge of a client’s cultural experience will use elements of that culture in creating therapeutic metaphors, examples and throughout the therapeutic dialogue.

Therapists will also elicit this material from clients by asking about topics such as, family stories and multigenerational parenting practices.

A therapist may also use language, symbols and stories from his own background to enrich the therapeutic dialogue.
4. Demonstrate knowledge of and respect for cultural values and practices.

The therapist is aware of cultural norms in a variety of contexts including: personal space, time orientation, gender roles, generational roles, dress, emotional expression and religion. The therapist gains credibility by accepting these values and avoids making unnecessary judgments based on culture-bound behavior.
5. Set collaboration goals that are consonant with culture and context:

Any conflict between therapeutic needs and cultural norms is a topic of active discussion and problem solving.
6. Support values and strengths from culture of origin.

Strong religious affiliation, support of extended family, resilience and humor are examples of the types of cultural strengths to be utilized and enhanced.
7. Adapt methods to culture.

Bernal, et al. (1995) describe specific techniques that culturally competent therapists use to enhance existing treatment models; these include: "modeling" to include culturally consonant traditions; "cultural reframing" of problems as partly reflecting economic and social realities; cultural hypothesis testing; use of genograms; "cultural migration/change dialogue"
8. Consider cultural context in implementation.

All aspects of treatment specifically address the context of culture and social conditions on the client. Key factors include: societal pressures/conditions; social supports and relationship to community; economic and social context of intervention; ethnic labeling/disproportional sanctions; stress of migration or acculturation.

Cultural Hypothesis Testing

Stephen Lopez

Make an informed guess as to possible cultural factors affecting treatment

Gather evidence through observation, questioning & consultation

Intervene Appropriately

Gather evidence of effectiveness of the intervention
https://www.youtube.com/watch?v=P5vz6iwV38U