Cultural Competence

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Introduction

The diversity of the United States has increased dramatically over the last 20–30 years and will continue to change in the next 40 years. According to the US Census, between 1980 and 2000, the number of Asian Americans increased by 230%, American Indians by 139%, Hispanic Americans by 142%, and African Americans by 32%. In contrast, the Caucasian population increased by 11% (US Census Bureau 2000). Twelve percent of the US population is foreign born with one foreign born parent, indicating that one in four people in the United States is a first or second-generation immigrant (US Census Bureau 2010). Projections by the US Census Bureau indicate that the Hispanic population will double from 2010 population levels by 2050, accounting for an increase in percentage from 2010 of 15 percentage points from 16.3% to 31.3%, and the Asian population will increase by 79%. Also of note is that the biracial population is projected to double from 1.8% to 3.7%. The US population could be 50% minority and 50% White as early as 2040, assuming high net immigration or is projected to be 42% minority groups in 2050, assuming zero net growth in international migration (Ortman and Guarneri 2009).

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These population demographic projections have significant implications for community mental health, as many immigrant and minority populations have their mental health needs taken care of by the public sector, bringing up issues of Limited English Proficiency (LEP), the proper use of interpreters, understanding the patient's explanatory models, and the use of complementary and alternative medicine. Further, the Institute of Medicine's report, *Unequal Treatment* (Smedley et al. 2002), indicated that ethnic minority patients have reduced access to services and receive a lower quality of medical and psychiatric treatment than mainstream patients even when socioeconomic status is matched with mainstream patients. Providers in community and other public sector settings such as the Veteran's Administration or the Indian Health Service will need to develop a set of culturally appropriate and sensitive attitudes and assessment skills and learn culturally specific values and beliefs to properly assess and treat the many ethnicities and minority groups that will be represented in their patient populations.

This chapter defines cultural competence and recovery as well as reviews important national and Federal policy documents supporting its use in community psychiatry, and describes practical strategies on how to apply its principles, including the use of the *Diagnostic and Statistical Manual, Text-Revision*, Fourth Edition (DSM-IV-TR)'s Outline for Cultural Formulation (OCF), as well as describe culturally appropriate treatments adapted from evidence based practices.

The chapter concludes with a discussion of examples of state and local legislation affecting the practice of culturally competent community psychiatry.

Stigma, Recovery, and Cultural Competence

Before addressing how to provide culturally appropriate care, we have to discuss the barriers that create the mental health disparities minorities experience that have been documented in *Unequal Treatment*, as stated above, the Surgeon General's Supplement to the Report on *Mental Health: Culture, Race, and Ethnicity* (USDHHS 2001), and the President's New Freedom Commission on Mental Health (2003). One major barrier is the stigma of mental illness, and it can be defined as a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and/or discriminate against people with mental illnesses. Stigma leads others to avoid renting to, living, socializing, and/or working with, or employing people with mental disorders especially people with severe disorders, which is then internalized, leading to low self-esteem, isolation, and hopelessness such that they conceal their symptoms and fail to seek treatment. At a systems level, it deters the public from seeking and wanting to pay for care. People of color, women, gays and lesbians, and/or of religious faiths other than Christian experience a "double stigma," that is to say that they are discriminated against for belonging to nonmainstream groups, and they still experience the stigma of having a mental illness.

Recovery-based practices can be thought of as the antidote to stigma, and can be defined as practices supporting a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence. The elements of recovery include the instilling of hope; the use of appropriate medication and treatments; client empowerment; the use of community support; mental health education; self-help, and spirituality/religion; and obtaining employment and participating in meaningful activity. Service providers can apply the principles of cultural competence to recovery-based treatment, which involves an acceptance of the culture that the patient considers to be theirs, and their experience in a culture that may not accept them as they are because of *racism, sexism, colonialism, or homophobia, and* may discriminate against them because of their gender, sexual orientation, religious beliefs, ethnicity, language, age, or country of origin. By acknowledging the differences between patients and the mainstream population, a provider can begin to build a patient's self-esteem and help them to develop coping skills to shield themselves from stigma and discrimination, making their community a safer place to be themselves. Strategies to achieve these goals include reducing the isolation caused by cultural differences and LEP by providing community and peer support, as well as linguistically appropriate services and mental health education, and even encouraging clients to learn more English. Cultural competence in recovery would mean creating patient-centered service plans, taking into account each person's individual cultural experience and avoiding stereotypical ideas that all people belonging to an ethnic group or speaking the same language have the same cultural beliefs. Trauma associated with discrimination, violence, or displacement must be acknowledged and addressed for healing to take place, as well as any medical needs, and substance abuse disorders. Treatment plans may include the use of traditional healers such as curanderos, shamans, medicine men, midwives, acupuncture, ayurvedic or herbal medicine, meditation, tai chi, and yoga, among others. Spirituality plays an important role and may or may not involve an organized religion and could be a belief in God, or a higher power, worshiping and respecting one's ancestors, or a belief in the spirit world. Recovery may also require the acquisition of new skills, job training, language proficiency, or obtaining decent housing, eligible entitlements and US citizenship. Finally, culturally competent recovery-based practices will help clients to reclaim their cultural identity that they may have tried to deny which would reduce their feelings of alienation from the mainstream. By providing support to culturally diverse individuals and valuing their differences, providers in the community can promote healing through self-acceptance, and stop the internalization of stigma (Ida 2007).

Definitions

The practice of culturally appropriate assessment and treatment can be described as being culturally competent, as first defined by Cross et al. (1989). Although there are many definitions, the one that may best capture the spirit of cultural competence is the definition stated by the Center for Mental Health Services (CMHS), which states that it has five principles, (1) accepting and respecting differences, as opposed to saying that all patients are the same, (2) continuing self-assessment of the clinician's attitudes towards culture and cultural differences, (3) paying attention to the way that differences or similarities between clinicians and patients affect the interaction, (4) learning about cultures and acquiring culturally specific resources, and (5) creating services that are culturally appropriate for the population served (SAMHSA 2001) (Table 15.1).

Another important concept is cultural humility, defined by Tervalon and Murray-García as a lifelong process of self-reflection and self-critique. The provider of culturally appropriate care is encouraged to develop a respectful partnership with each patient through person-centered interviewing, that explores similarities and differences between his or her own and each patient's priorities, goals, and capacities. Ideally, the conclusion of this cross-cultural exploration would be to develop an approach to managing clinical problems based on negotiation between the two culturally distinct perspectives. A culturally competent provider is open and flexible enough to identify the importance of differences between his or her orientation and that of each patient, and to explore compromises that would be acceptable to both. Thus, a clinician applying the principles of cultural humility would not expect himself or herself to be an expert in cultural minutiae, or to take on other healer's roles such as a minister or an herbalist, but recognize the need to refer a patient for appropriate services or obtain appropriate consultation (Tervalon and Murray-García 1998).

Before I proceed further, I should define the terms culture, race, and ethnicity. Culture can be

Table 15.1 Definition of cultural competence

Acceptance and respect for differences
Continuing self assessment regarding culture
Attention to the dynamics of difference
Ongoing development of cultural knowledge and resources
Dynamic and flexible application of service models to meet the needs of minority populations

Source: SAMHSA (2001)

defined as a set of values, traditions, and beliefs that are passed from generation to generation. Race is not biologically determined, but is a socially defined concept that groups individuals on the basis of skin color and other physical features. Ethnicity is the group that one feels one belongs to, and overlaps with culture. Therefore, within the group who self-identify their ethnicity as Chinese, there may be other cultures represented, based on regional, political, and historical differences. Conversely, cultures can cut across ethnicities, for example, Western, military, or medical cultures.

Federal Policies and National Standards

The Federal government, as represented by Congress, and the agencies they fund, determines funding priorities and therefore the shape and form of the delivery of services. In 1998, the US Department of Health and Human Services (USDHHS) Office of Minority Health (OMH) conducted a national level review of existing cultural and linguistic competence standards and measures in order to prepare and draft of national standards, known as the CLAS (Culturally and Linguistically Appropriate Services) Standards (Office of Minority Health 2000). The standards were informed by a careful review of key legislation, regulations, contracts, and standards currently in use by Federal and state agencies and other national organizations. The proposed standards were then developed with input from a national advisory committee of policy administrators, healthcare providers, and health services

Table 15.2 National standards for culturally and linguistically appropriate services (CLAS)

Culturally competent care
Health care organizations:
1. Should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language
2. Should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area
3. Should ensure that staff at all levels and across all disciplines receive ongoing education and training in CLAS delivery

Language access services
Health care organizations must:
4. Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency (LEP) at all points of contact, in a timely manner during all hours of operation
5. Provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services
6. Assure the competence of language assistance provided to LEP patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)
7. Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area

Organizational supports for cultural competence
Health care organizations should:
8. Develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide CLAS
9. Conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations
10. Ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated
11. Maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area
12. Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS related activities
13. Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers
14. Be encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information

Source: Adapted from Office of Minority Health (2000)

researchers. Fourteen standards were created, defining culturally competent care, i.e., care that is compatible with cultural health beliefs, and in the preferred language, how to provide services in the appropriate languages for the client. These standards included providing signage, literature, and interpretation in the patient's preferred language so that family members do not have to be used as interpreters, and supporting cultural competence in the organization, such as strategic planning that specifies hiring and retention practices that encourage diversity such that staffing matches the patient population, with training in cultural competence principles, like working with the community and having ongoing assessment of cultural competence practices, demographics of the patient population, and a review process that is available to the public (see Table 15.2).

The first report on culturally competent mental health care created by a government agency was *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups* first published in 1998 by the Western Intercollegiate Commission for Higher Education, and later distributed by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2001), which detailed overall system standards and implementation guidelines, such as cultural competence planning, community outreach and education, and quality monitoring and improvement, as well as human resource development. These also included clinical standards, such as access, triage, assessment, treatment, and discharge planning, and case management. Finally, the report delineated guidelines for communication and patient self-help and carefully outlined the provider competencies of culturally specific knowledge, and culturally generic attitudes, and skills.

In 2000, the Office of Civil Rights (OCR), empowered by White House Executive Order 13166: "Improving Access to Services for Persons with Limited English Proficiency," required that all Federal agencies formally address how they would provide access to their services to people with LEP. The USDHHS issued guidance that included an "Effective Plan on Language Assistance for LEP Persons," stating that programs receiving Federal funds must (1) identify individuals who need language services, (2) have language assistance services, (3) train staff to appropriately work with clients who need language assistance, (4) provide notice for people that services are available, such as signs in their language, and (5) that such programs must be monitored and updated (USDHHS 2000).

The next report to be released was the Supplement to the Surgeon General's Report on Mental Health, *Mental Health: Culture, Race, and Ethnicity* (USDHHS 2001) in 2001, which established that ethnic minorities do not utilize mental health services as much as the majority population and that "culture counts." The supplement documented striking disparities in mental health care for racial and ethnic minorities involving access to care, appropriateness of treatment, overall quality of care, and treatment outcomes, as well as the fact that minorities are poorly represented in research studies. Together, these mental health disparities impose a greater burden of disability on racial and ethnic minorities. Some examples from each of the four chapters on the major racial and ethnic groups follow:

- Disproportionate numbers of African Americans are overrepresented in the most vulnerable segments of the population—people who are homeless, incarcerated, in the child welfare system, victims of trauma—all populations with increased risks for mental disorders.
- As many as 40% of Hispanic Americans report that they have LEP. Because few mental health care providers identify themselves as Spanish-speaking, most Hispanic Americans have limited access to ethnically or linguistically similar providers.
- The suicide rate among American Indians/Alaska Natives is 50% higher than the national rate; rates of co-occurring mental illness and substance abuse (especially alcohol) are also higher among Native youth and adults. Because little data has been collected, the full nature, extent, and sources of these disparities remain a matter of conjecture.
- Asian Americans/Pacific Islanders who seek care for a mental illness often present with more severe illnesses than other racial or ethnic groups. This, in part, suggests that stigma and shame are critical deterrents to service utilization. It is also possible that mental illnesses may be undiagnosed or treated later in their course because they are expressed in symptoms of a physical nature (Tervalon and Murray-García 1998).

The report concluded with "A Vision for the Future," in which recommendations were grouped in six areas: (1) continue to expand the science base, (2) improve access to treatment, (3) reduce barriers to treatment, (4) improve quality of care, (5) support capacity development, and (6) promote mental health.

In 2003, the President's New Freedom Commission on Mental Health issued its report entitled *Achieving the Promise: Transforming*

Mental Health Care in America (New Freedom Commission on Mental Health 2003). Through this document, the Bush Administration created policy to guide how mental health and health professionals ought to be recruited and trained to deliver services to diverse populations. Of the six goals discussed as strategies to transform the mental health system, two are most relevant to minority mental health disparities: (1) mental health care is consumer and family-driven and (2) disparities in mental health services are (to be) eliminated. Some of the specific recommendations included improving access to quality care that is culturally competent by (1) recruiting and retaining racial and ethnic minority and bilingual professionals, (2) developing and including curricula in all Federally funded health and mental health training programs that address the impact of culture, race, and ethnicity on mental health, (3) developing training and research programs targeting services to multicultural populations, (4) engaging minority consumers and families in workforce development, training, and advocacy.

Finally, in 2005, the National Institutes of Health (NIH), along with the National Institute of Mental Health, instituted a policy that all investigators must describe how they will recruit underrepresented groups, such as ethnic minorities, women, and other nonmajority groups in their experimental protocols. According to the guidance, "NIH also requires a description of the proposed outreach programs for recruiting sex/gender and racial/ethnic group members as subjects (NIMH 2005)." Thus, investigators are required to describe how they will recruit subjects that represent all of the major underrepresented groups, and not just the mainstream and majority group, or risk not being approved for research funding.

Clinical Approaches

Staff Training: Diversity Training vs. Cultural Competence Training

Staff that provide mental health services to a diverse population requires training that encompasses culturally relevant knowledge, attitudes,

and skills. Cultural knowledge can be obtained from books, such as *Ethnicity and Family Therapy*, by McGoldrick et al. (2005), but these references can also be used to create stereotypical lists of qualities and generalities that trainees memorize, and may give trainees a false sense of security that they "know" everything about a particular group after reading a single chapter. The references may provide give a good starting place for trainees to understand what is normative for an ethnic group, and how to begin asking more culturally pertinent questions to understand the client that they have in their office.

In order to use resources such as *Ethnicity and Family Therapy*, clinical staff and trainees should have diversity training, which helps them to develop attitudes that are accepting of cultural differences, then cultural competence training that teaches culturally-generic skills, and then culturally-specific knowledge. The reader interested in designing a training program in diversity and cultural competence is referred to the excellent books suggested as resources at the end of this chapter.

Concerning the training in attitudes, it is my view that cultural competence training for staff begins with creating an atmosphere where differences are acknowledged and celebrated. This begins with hiring staff from representative groups to allow the cultural perspective to be shared with other staff members, as well as providing culturally appropriate assessment and treatment planning, a process which begins with the use of the DSM-IV-TR OCF, as discussed in the next section. Briefly, this means taking a person-centered approach, with a focus on his or her cultural identity, as well as personal models of illness and expected treatment; not just using the DSM-IV-TR as a basis for diagnosis, but using a more culturally relevant approach, such as finding out what name the patient gives to their condition. The clinic can have case conferences that highlight the cultural aspects of cases, and provide much needed examples. The clinical environment should have signage in the appropriate languages and artwork representative of the patient population.

Diversity training exercises help staff to recognize similarities and differences in themselves,

Table 15.3 Discussion questions from *understanding race, ethnicity, and power*

What was your first experience with feeling different?
What is your ethnic background? What has it meant to belong to your ethnic group? How has it felt to belong to your ethnic group? What do you like about your ethnic identity? What do you dislike?
What are your feelings about being White or a person-of-color? How do you think others feel?
Adapted from Pinderhughes (1989)

Table 15.4 The *Diagnostic and Statistical Manual, Text-Revision* (DSM-IV-TR) outline for cultural formulation (OCF)

A. Cultural identity of the individual
B. Cultural explanations of the individual's illness
C. Cultural factors related to psychosocial environment and levels of functioning
D. Cultural elements of the relationship between the individual and the clinician
E. Overall cultural assessment for diagnosis and care
Source: American Psychiatric Association (2000)

and become aware of subtle prejudices and biases that staff may have. A common 1-hour training exercise is to have staff introduce themselves in groups of six to eight, but in a way that does not only just chronicle their training and jobs, but reveals where they are from, what languages they speak, and what are the important parts of their identity. They may even talk about the origin of their names and its meaning(s). On another occasion, a potluck can be scheduled when staff may also bring in a comfort food or cultural healing practice, such as chicken soup, from their cultural group, explain to others what is in it, and how their family explained to them how it would help to make them feel better. Another approach is to celebrate ethnic holidays, such as Chanukah, Chinese New Year, Cinco de Mayo, Kwanzaa, and Ramadan, and have a brief presentation on the holiday's meaning and customs. Finally, an hour can be taken with a group of eight to explore discussion questions from *Understanding Race, Ethnicity, and Power* by Pinderhughes (1989) (Table 15.3).

DSM-IV-TR Outline for Cultural Formulation

The *Diagnostic and Statistical Manual*, 4th Edition (DSM-IV) (American Psychiatric Association 1994) and DSM-IV-TR [Text Revision] (American Psychiatric Association 2000) both include Appendix I, which includes the DSM-IV OCF and a glossary of culture bound syndromes, which are diagnostic descriptions that may be understood in the context of local cultural beliefs, and can be variants of diagnoses

seen in clinical practice in the United States and other Western Countries, such as neurasthenia, a somatic variant of major depressive disorder, that is used in the *Chinese Classification of Diseases*, 10th Edition. The DSM-IV-TR OCF is a useful framework for organizing a culturally sensitive assessment of a culturally diverse patient, and it contains the following five sections: Part A is the cultural identity of the individual, Part B is the cultural explanations of the individual's illness, Part C includes the factors related to psychosocial environment and levels of functioning or supports and stressors, Part D is the cultural elements of the relationship between the individual and the clinician, and Part E is the overall cultural formulation, which integrates both the patient's and clinician's models of illness and treatment (Table 15.4).

Part A: The Cultural Identity of the Individual

Asking a patient about their cultural identity can be accomplished by performing a social and developmental history with attention being paid to the patient's country of birth, ethnicity of his or her parents and grandparents, and language(s) spoken. Ethnicity may also be assessed by asking the patient directly: what his or her name means, or what is his or her ethnic background? The "Addressing" framework from Hays (2008), can be useful here, as a checklist of things to explore, using the letters of the word "Addressing" in the following way: "A" is for age and generational influences, and is useful for examining the interaction between generations, especially when the parents are from another country, and the patient

Table 15.5 Addressing framework

Age and generational influences
Developmental and acquired
Disabilities
Religion and spiritual orientation
Ethnicity
Socioeconomic status
Sexual orientation
Indigenous heritage
National origin
Gender

Source: Hays (2008)

Table 15.6 Kleinman's eight questions

What do you call your illness? What name does it have?
What do you think has caused the illness?
Why and when did it start?
What do you think the illness does? How does it work?
How severe is it? Will it have a short or long course?
What kind of treatment do you think the patient should receive? What are the most important results you hope she receives from this treatment?
What are the chief problems the illness has caused?
What do you fear most about the illness?

Source: Kleinman et al. (1978)

is the second generation here. "D" is for developmental and acquired, and the second "D" is for disabilities, another aspect of differences. "R" is for religion and spiritual orientation, a very important aspect of a patient's identity. "E" is for Ethnicity, and it is important for clinician to understand how ethnicity is different from nationality, because a patient can have a different ethnicity that may be expected just from the nationality. "S" is for socioeconomic status, which is an important parameter in an individual's experience of their life. "S" is also for sexual orientation, which must be directly assessed, as it is easy to assume that a patient is heterosexual. "I" is for indigenous heritage, or culture that is passed down. "N" is for national origin, which is important to determine what environment that the patient experienced as a child and young adult, but is insufficient in and of itself, as national origin or nationality does not necessarily equal ethnicity. "G" is for gender, as men and women have different gender roles to fulfill, and may not feel comfortable with them. Finally, I would add an "L" to the mnemonic for language, as many patients speak a variety of languages, but prefer one to the other (Table 15.5).

Part B: Cultural Explanations of the Individual's Illness

The clinician's task is to identify how the person understands his or her illness, not only how symptoms fit into the DSM-IV-TR diagnostic criteria. Kleinman et al. (1978) wrote about the distinction between the disease, which is an observable physical phenomenon, and the illness,

which is how the patient experiences the disease through his or her cultural viewpoint. They went on to describe a set of eight questions that involve asking the patient what they think is the explanation for their illness: its name, how it works, how severe it is, and what problems it has caused. The clinician continues by asking about what kind of treatment is expected, both by the person and by the person's family (see Table 15.6). By inquiring about the person's understanding of the illness in their terms, clinicians can gain important insights into how people understand their disease and gain information that will be useful in the negotiation of their treatment with the person. At this time, the clinician may inquire about other healers that the person may have consulted prior to coming to the clinician's office, as many cultural groups have indigenous healers or alternative explanations for the causes of illness. The clinician can then inquire about herbal or organic treatments that may not be compatible with prescribed medications, as well as show interest in the person's journey into health.

Part C: Cultural Factors Related to Psychosocial Environment and Levels of Functioning

Part C of the OCF includes the cultural factors involving the individual's supports and stressors, and they can be assessed during the taking of the developmental or social history. In this section, we as clinicians would like to understand how an individual fits in or not with his or her community and extended family and his or her primary

social supports. Important things to ask about are the person's primary relationships, educational level, occupational, functional levels, and goals. Also important is relationship to parents, aunts and uncles, cousins, and religious community. Patients may have ambivalent relationships between their parents and/or religious/ethnic communities, such that the very group that they derive their support from is also a stressor. Religious beliefs are a part of an individual's cultural identity and must be explored because they may guide his or her decision-making about mental health treatment. The extended family may be the last word in deciding if a course of treatment may be followed or not.

Part D: Cultural Elements of the Relationship Between the Individual and the Clinician

The fourth part of the DSM-IV-TR OCF refers to how the cultural identity of the therapist affects the therapeutic relationship. The most common situation seen is when the patient is a minority and the clinician represents the mainstream culture. The patient may be reluctant to engage with the mainstream clinicians over feelings that the therapist may not understand their experience, or in fact, be biased against them. Or they may be very deferential to the clinician, while not completely agreeing with him or her indicating agreement while actually not following the therapist's advice, not wishing to confront the therapist because of culturally determined roles involving a deference to authority figures. With more minority therapists being trained, the dyad may be matched in some ways, but not in others, and there may be a false sense of security on the therapist's part that they understand the client, and that they do not have to ask particular questions, because the answers are already known by the therapist, due to his or her knowledge of their shared culture, or that parts of the history are too sensitive to talk about as agreed upon by their shared cultural group. Patients may also react to the clinician with an overly positive transference, feeling that their clinician is omnipotent and can offer relief from their symptoms and causing strong negative feelings when it is

discovered that the clinician has human frailties or otherwise disappoints. In other situations, the patient may dislike his or her same ethnicity therapist, and request one who is more mainstream with the belief that, as that therapists of his or her own race are inferior to mainstream therapists, a projection of their internalized racism, referred to by Comas-Diaz and Jacobsen (1991) as "auto-racism."

Part E: Overall Cultural Assessment for Diagnosis and Care

The final part of the DSM-IV-TR OCF is the overall assessment for diagnosis and care, which involves integrating Western illness concepts and the patient's explanatory models and adressing information gathered in the first four parts, such as their cultural identity, stressors and supports, and their relationship with the clinician, along with skillful negotiation of the treatment plan using the both Western and indigenous explanations of illness, using the clinician as the bridge between them. Having the services of a cultural consultant or cultural broker, or a clinician familiar with the cultural group of the person can be helpful in determining cultural norms, simplifying the discussion of what is cultural and what is pathological. The consultant provides an important context for the interpretation of symptoms, of illness and healing beliefs and practices, and understanding of the person's role in family, community, and dominant culture. There are three good examples of cultural consultation services, one in Montreal, QC in Canada (Kirmayer et al. 2003), and one in Sacramento, CA (Ton et al. 2005), and London, England (Cultural Consultation Service 2012).

Applications of Culturally Effective Treatment

In this section, through examples, I will further illustrate the clinical principles described above and how the key to engaging people in ethnic minorities into mental health services is to combine the principles of adapting services and systems to population needs, understanding and

accepting their cultural beliefs about illness, and where applicable, employing the principles of ethnopsychopharmacology.

Southeast Asian Communities

David Kinzie wrote about *The Therapist Variable* in which he described the trauma experienced by Southeast Asian patients, and that they have four primary needs, safety, both physical and emotional, predictable and stable relationships, reduction of symptoms, and the reestablishment of social relationships (Kinzie 2001). According to Kinzie, the therapist must be able to listen to a person's trauma without interruption, and be present as a dependable and stable relationship. The therapist is required to believe the evil that humankind has done to their fellow humans, yet still believe that healing is possible, and to receive gifts of modest value from traumatized Southeast Asians, such as prayers, seasonal dishes or social invitations, despite training to not accept gifts of any kind, as it is therapeutic for them and represents a culturally appropriate way for a person to honor the therapist–patient relationship.

Hinton and Otto described a way of modifying Cognitive Behavioral Therapy (CBT) for the treatment of post traumatic stress disorder (PTSD) in Cambodians who conceived of their illness as being caused by bad "wind" or muscle tension or dizziness, which may have been caused by forced labor, chronic starvation and sleep deprivation experienced in the killing fields (Hinton and Otto 2006). *Wind* is conceived as a source of energy flowing through the body, and a loss of wind, signified by tension in a joint would lead to bad health outcomes, like the death of the limb away from the tension due to the lack of blood flow, and to the dangerous ascent of wind and blood in the body, into the trunk of the body. The catastrophic cognition would be that this wind could cause a heart attack or the person's breathing to stop, or rupture of the blood vessels in the neck or into the head, leading to fainting, blindness, or death. Treatment for the bad wind would be "cupping" or causing redness on the skin by applying negative pressure thorough a heated glass bulb applied to the skin, or coining, using coins to rub the skin, causing a round red mark on the skin. In

the adapted CBT protocol, the therapist introduces the "Limbic Kid" to explain the automatic responses and thoughts associated with the catastrophic cognitions (Otto and Hinton 2006). The therapist then induces dizziness by having the person play a childhood game called "hung," where she or he holds his or her breath while running to retrieve a stick, experiencing dizziness, but no other ill effects, allowing a disconnection of the physical sensation from catastrophic cognitions. Finally, the therapist incorporates a Buddhist ritual, the three bows, with three statements. Thus, the first bow acknowledges the pain. The second is the acceptance that it has lingering effects, and the third is returning a focus to the present, and planning to have a good life in the present.

Another example is a Vietnamese support group that used principles of wellness and adaptation to the host culture by serving tea, doing relaxation exercises, and teaching English to the members (Truong and Gutierrez 2009). The group leaders, third year psychiatry residents who were ethnically Vietnamese and bilingual in Vietnamese and English, found that the group members were willing to share in a group format, despite predictions found in the literature that Asians would not feel comfortable in groups due to cultural prohibitions against sharing private matters (Paniagua 2005), showing again that one cannot predict the behavior of all Asians with generalizations about an entire ethnic group that is heterogeneous.

Hispanic Communities

Other examples of groups treatment for ethnic minorities include CBT for depression adapted for use in Spanish speaking patients (Miranda et al. 2006). Miranda and her colleagues reported that in an ethnically diverse clinical population diagnosed with major depressive disorder, those randomized to CBT or medication management did better than those referred to a community mental health center (Miranda et al. 2006). The authors noted that community outreach was needed to educate people about their illness and the types of treatment. Despite providing transportation and childcare, only slightly over one

third were able to attend more than six sessions that had been appropriately translated to Spanish for those who were monolingual, illustrating the difficulties encountered by study subjects in making appointments. The group taking medications did slightly better, implying that psychopharmacology was still effective, but less so without outreach and support.

Ruiz and Langrod identified the importance of spiritual beliefs in the Hispanic population of the Bronx, and in order to increase the engagement of this clinic with the community, recruited mediums, accepted referrals from and referred cases to mediums, actively outreached to the community by visiting spiritual centers, conducting ethnographic observations, and exchanging views of treatment and explanatory models with *espiritistas* and other spiritual authorities (Ruiz and Langrod 1976). Barrio (2000) similarly describes the importance of outreach to and engagement of the family and community through community support centers, which can bridge gaps between the community mental health center and the ethnically diverse populations they serve.

Using Systems to Aid Culturally Competent Services

Another strategy, similar to Barrio's description of creating systems linkages, is using access services, usually provided by community agencies that can provide language translation services. For example, Asian Pacific Community Counseling in Sacramento, CA provides language and culturally appropriate psychotherapy through the Transcultural Wellness Center (Asian Pacific Community Counseling 2011), but also serves as a linkage for people to enter the county mental health system (Sacramento County-Specialty Mental Health Services 2011). Finally, another approach that has been helpful in linking ethnic minority patients from the community to mental health services has been the Bridges program at the Charles B. Hwang Community Health Center (CHC). This model capitalizes on systemic integration of physical health and mental health services (discussed in detail in Chapter 14) at the Charles B. Hwang CHC. Chinese patients

seen in primary care are referred to mental health professionals in the same building as their primary care colleagues, thus reducing the stigma they might experience if they were to be referred to a free standing mental health clinic (Chen et al. 2003).

Ethnopsychopharmacology

Ethnopsychopharmacology is the study of how ethnicity affects the activity of psychoactive agents. In a recent article, Chen et al. (2008), explain that there are many biological, environmental, and psychological reasons for the broad range of responses seen in different ethnic groups. The hepatic enzyme, cytochrome P450 and its subtypes CYP2D6, CYP3A4, CYP1A2, CYP2C19, and CYP2B6 are responsible for the metabolism of many psychotropic medications. Depending on the number of copies of genes coding for these enzymes, a person may be a slow metabolizer, where a small amount of a medication can have as big an effect as a normal dose, or a normal dose may have intolerable side effects. A person may be an ultrafast metabolizer, when even a large dose of medication can be experienced as not taking the medication at all. Diet and smoking also affects the drug metabolism, sometimes inhibiting or accelerating its rate. Finally, the patient's expectation of how the drug will work may affect the perception of the actual effect, or may cause an effect of its own (the placebo effect). On a clinical level, psychiatrists and primary care practitioners are well advised to start with a low dose and advance titration slowly in case the patient is a slow metabolizer. Genetic screening tests are available that can genotype a patient with a cheek swab sample, making it possible to predict the activity of a particular enzyme and adjust dosages accordingly (AssureRx 2012).

Culturally Competent Interventions at State and Local Levels

Clinicians need to have the support of their organization to provide culturally sensitive mental health services, as either seen by an application

of the CLAS standards or other systematic cultural competence framework. California has an excellent example of a mental health specific plan for culturally competent care in its California Cultural Competence Plan. In 1993, California began the process that became known as the California Cultural Competence Plan (California DMH [Department of Mental Health] 2003). Each of the 58 California counties had to assess the percentages of the languages spoken by their patients and providers, and were required to provide services and brochures in any language spoken by 3,000 Medi-Cal (California's version of Medicaid) members or 5% of the Medi-Cal population in that county. County agencies are required to monitor their staff composition and ensure that their staff diversity mirrors the patient diversity. The Cultural Competence plan also requires that training in cultural competence be provided for mental health clinicians on a continuing basis. Washington, California, Connecticut, New Jersey, and New Mexico all require continuing medical education courses include material on cultural competence, or require cultural competence training as a condition of licensure for physicians (USDHHS Office of Minority Health 2010).

Conclusions

US population projections by the US Census Bureau show that the number of minorities will increase at a higher rate than the general population, and in fact equal the majority population between 2040 and 2050. Community mental health providers will see the majority of these patients, as they are likely than mainstream patients to be under or not insured, particularly if they are indigent or newly immigrated to this country. The Federal government and states like California provide guidance on how to adapt our mental health services to meet the needs of the diverse populations that they serve. On a practical level, application of the DSM-IV-TR OCF can inform the clinician's assessment and treatment planning, using a culturally-appropriate skills

based interview, informed by culturally-specific knowledge, perhaps provided by a cultural broker or consultant, and the engagement of the patient and their family in discussing their illness beliefs and practices. A careful review of the literature reveals examples of how evidence based practices such as CBT for depression can be adapted to different language and cultural groups, and the importance of enlisting community support, linkage, and providing outreach, education, childcare, and transportation if possible, as well as the importance of using religion and spirituality when appropriate, and complementary and alternative medicine, or other culturally appropriate treatments, as well as using principles of ethnopsychopharmacology, in terms of starting with small doses, and noting the effects of diet and smoking on the metabolism of psychotropic medications. By taking a holistic, culturally competent, and patient centered approach, the community clinician can deliver effective and culturally appropriate recovery based mental health care.

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