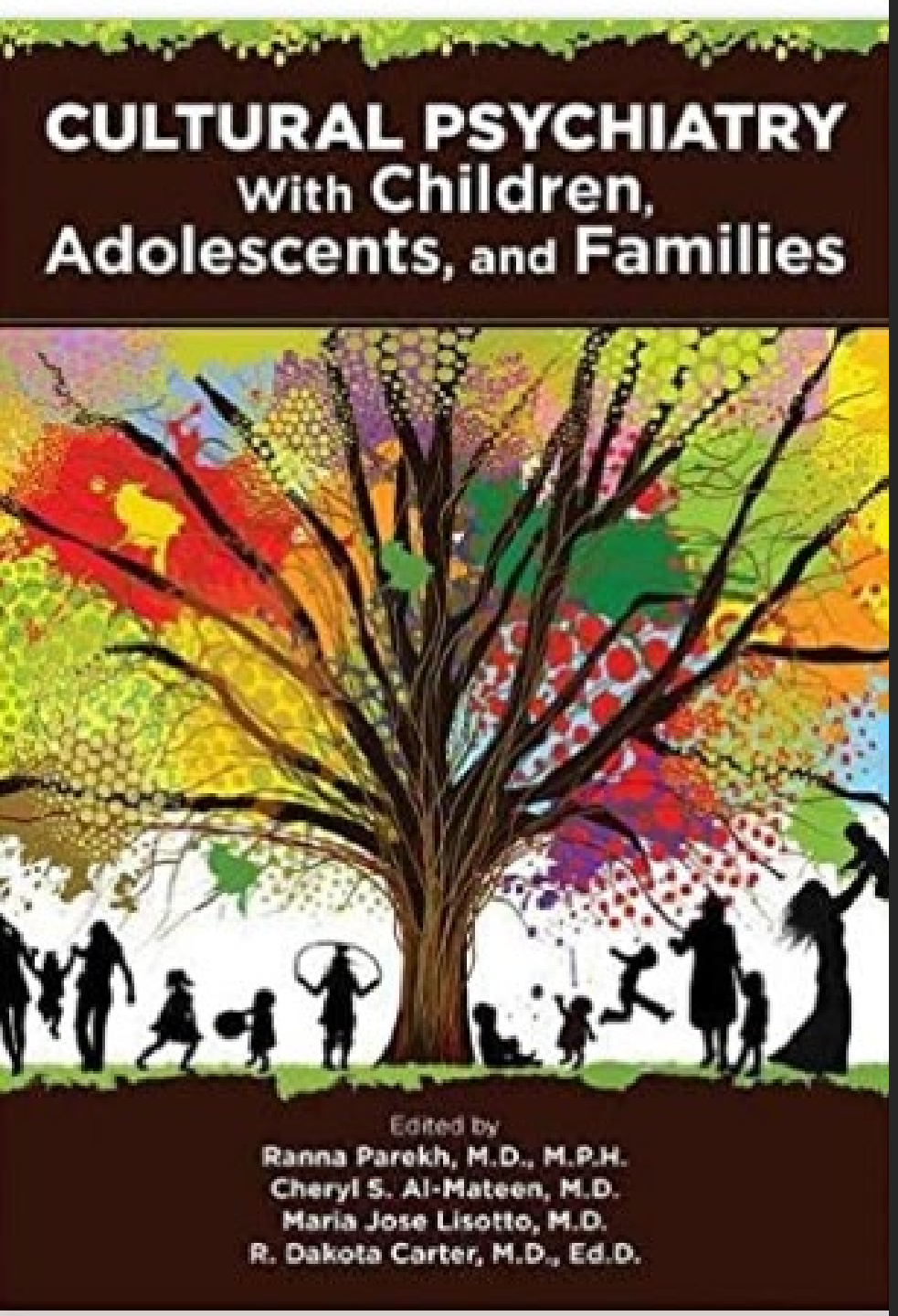


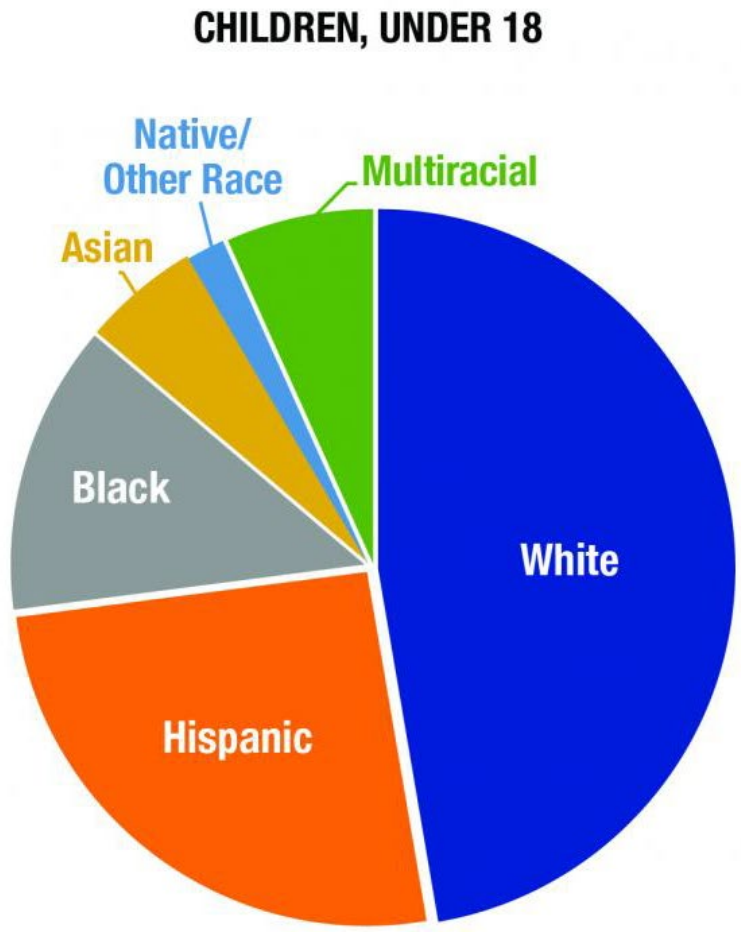
Cultural Psychiatry With Children, Adolescents, and Families: Overview for Practice

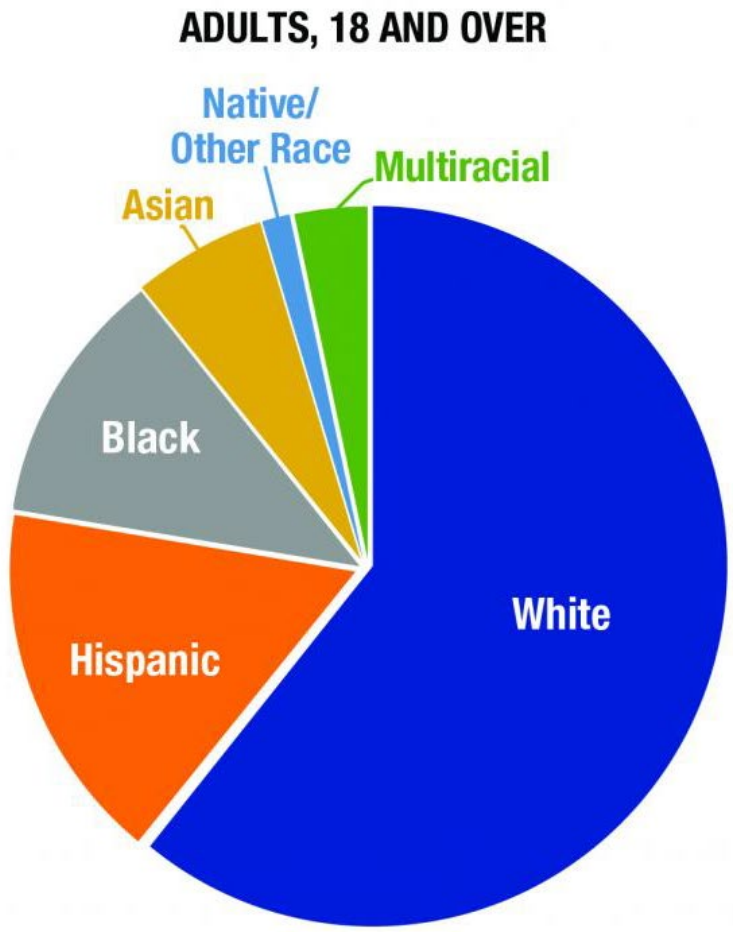
R. Dakota Carter, MD, EdD

LEARNING OBJECTIVES

- Describe the relevance of Cultural Psychiatry/ culture in mental health
- Review Parts I through V (as an example of culture and intersectionality)
- Overview of CFI and its utilization
- Applying knowledge to blended case examples

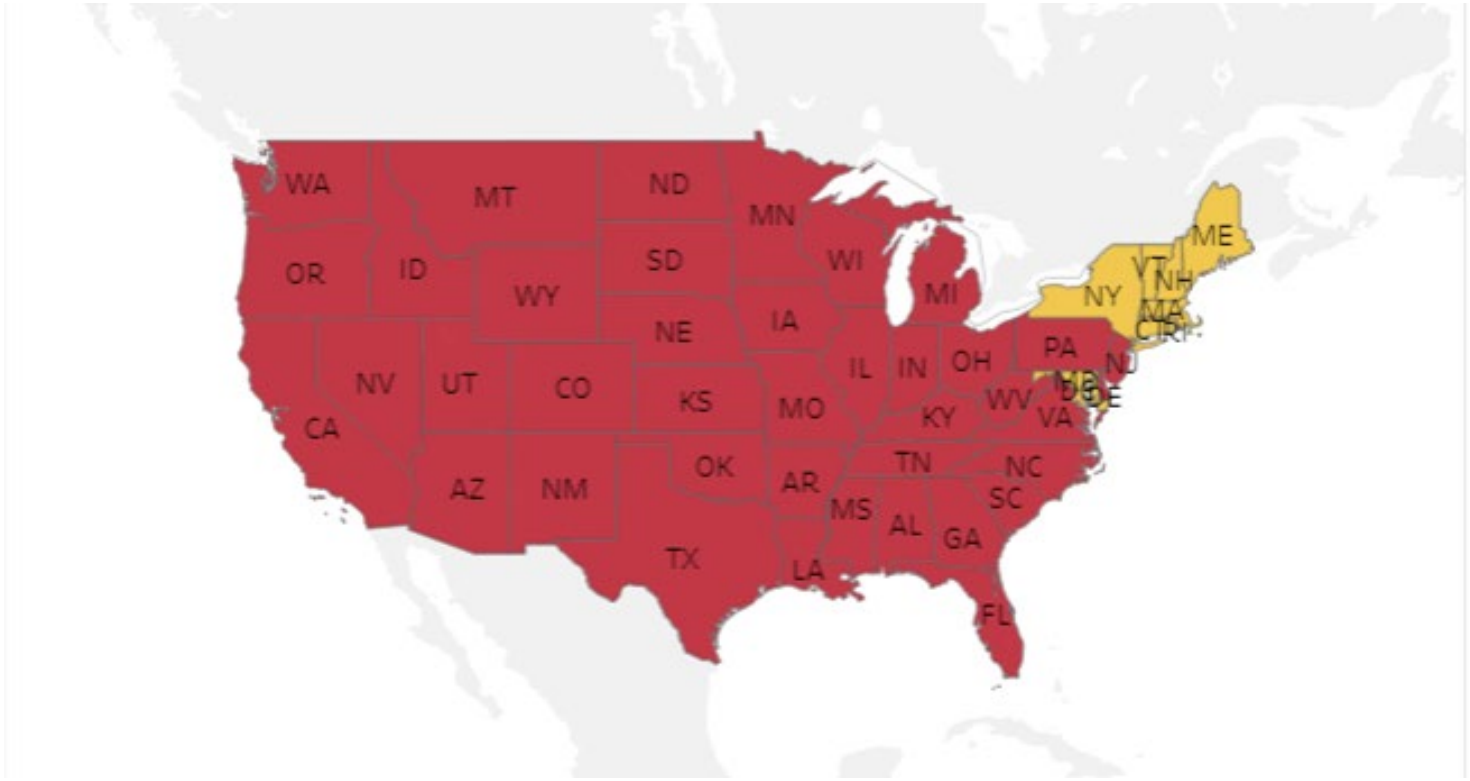
US Population by Age, Race, Hispanic Origin 2020





Who needs to be informed on culture in mental health?

- All providers for children, including child and adolescent psychiatrists, psychologists, social workers, therapists, pediatricians, educators and hospital administrators.



CAPs per 100K

- Mostly Sufficient Supply (>= 47)
- High Shortage (18-46)*
- Severe Shortage (1-17)*

Definitions

Cultural Psychiatry: The study and treatment of mental illness in individuals, guided by thoughtful consideration and integration of race, ethnicity, religion, and cultural backgrounds.

Intersectionality: Coined by Prof. Kimberle Crenshaw in 1989; idea that when it comes to thinking about how inequalities persist, such categories as gender, race, and class are best understood as overlapping and mutually constitutive rather than isolated and distinct

Minority Stress Model: Theoretical framework that identifies negative societal stressors that lead to negative physical and mental health via layered cognitive, affective, interpersonal, and physiological responses.

APA Definition of Culture

Values, orientations, knowledge, and practices that individuals use to understand their experiences

Aspects of a person's background, experience, and social contexts that may affect his or her perspective

The influence of family, friends, and other community members (the individual's *social network*) on the individual's illness experience

Definitions (continued)

Microaggression

- Microassaults: “Explicit, conscious racial or derogatory actions intended to hurt.”
- Microinsults: “Communications that convey rudeness and insensitivities and demean a person’s heritage or identity.”
- Microinvalidation: “Communications that exclude, negate or nullify the psychological thoughts, feelings or experiential reality of a person.”

Definitions (continued)

Assimilation: Process in which a minority group or culture comes to resemble a dominant group or assume the values, behaviors, and beliefs of another group

Acculturation: Multidimensional, continuous, and dynamic process through which immigrant retain aspects of their native culture while simultaneously adopting the new society's culture, foreign attitudes, norms, values, and behaviors. Influenced by generational differences: with each generations, there will be a greater degree of acculturation.

Acculturative Stress: Perceived (psychological, emotional or health) stress in relation to the process of adapting to a different community.

Definitions (continued)

Cultural Competence: Ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.

Cultural Humility: Ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important o the person." This is a lifelong process of self reflection and self critique whereby the individual learns about another's culture after an examination of her or his own beliefs and cultural identities.

Textbook's Contents, Format, and Approach

- Updates how the practitioner utilizes concepts related to cultural competency.
- Reviews introductory concepts and definitions such as the knowledge base, skills and attitudes related to the practice of culturally-competent care with children, adolescents, transitional age youth and their families.
- How to use and leverage DSM-5 Cultural Formulation and Interview.
- An overview of major racial/ethnic groups.
- Review of cultural concepts that impact individuals in any racial or ethnic group, such as spirituality, sexual orientation and gender identity.
- Address external influences such as social determinants of health, immigration status and the impact of media on children.
- Enhance the reader's understanding of the clinical implications of all chapters including the impact of culture on specific interventions and the culture of technology itself.
- Understanding assessed via several blended patient/client cases and self assessment questions.

Part I: Race and Ethnicity

Chapter 2: "The Black Diaspora: Cultural Psychiatry Perspectives on African American Children and Adolescents and Their Families"

Chapter 3: "A Broad Overview of American Indian, Alaskan Native, and Native Hawaiian/Pacific Islander Cultures"

Chapter 4: "Mental Health in Asian American Populations"

Chapter 5: "Bridging the Gap in Psychiatric Care of Latinx Youth and Families"

Chapter 6: "The Role of Culture, Stigma, and Bias on the Mental Health of Arab Americans Youth"

Part II: Cultural Concepts

- Chapter 7: "Gender and Sexuality in the Twenty-First Century: Cultural Psychiatry for Children, Adolescents, and Families"
- Chapter 8: "Religion and Spirituality in Child and Adolescent Cultural Psychiatry."
- Chapter 9: "Diverse Families and Family Treatment"

Part III: External Influences

- Chapter 10: “Social Determinants of Child and Adolescent Mental Health”
- Chapter 11: “Aliens, Illegals, Deportees: Children, Migration, and Mental Health”
- Chapter 12: “Clinical Strategies to Address the Mental Health of Forcibly Displaced Children (Refugees, Asylum Seekers, and Unaccompanied Minors): The Role of Silence, Family, and Socioecological Resilience”
- Chapter 13: “The Global State of Child and Adolescent Mental Health”
  Chapter 14: “Digital Media, Culture, and Child and Adolescent Mental Health”
- Chapter 15: “Culture of Technology: Use of Telepsychiatry and Other Advances to Engage Children, Adolescents, and Transitional Age Youth”
- Chapter 16: “Rural Psychiatry”

Part IV: Developmental Stages, Family, and Clinical Implications

- Chapter 17: “Infant Psychiatry: Culture and Early Childhood”
- Chapter 18: “Adoption and Foster Care Systems”
- Chapter 19: “Microaggressions: Effects in Early Life and Strategies to Overcome”
- Chapter 20: “Cultural Aspects of College Mental Health”

Section V: Applied Concepts

Chapter 21: DSM-5 Outline for Cultural Formulation and Cultural Formulation Interview: Complex Case Examples

Chapter 22: Advocacy

When to use the Cultural Formulation Interview

(*DSM-5-TR update page 863*)

- Difficulty in diagnostic assessments owing to significant differences in cultural, religious, or socioeconomic backgrounds of clinician and individual.
- Uncertainty about fit between culturally distinctive symptoms and diagnostic criteria.
- Difficulty in judging illness severity or impairment.
- Divergent view of symptoms or expectations of care based on previous experience with other cultural systems of healing and health care.
- Disagreement between the individual and clinician on course of care.
- Potential mistrust of mainstream services and institutions by individuals with collective histories of trauma and oppression
- Limited engagement in and adherence to treatment by the individual

Principles for using the DSM-5 Cultural Formulation Interview with children and youth

(Parekh et al 2021, p. 359; adapted from Rousseau and Guzder 2016 ,p. 158)

- Brevity is essential; attention span and concentration increase with age and developmental stage. Resist the urge to get all the information in one sitting. Consider the use of additional modalities (e.g., observation, drawing, play).
- Adapt the questions to the child's or adolescent's cognitive and linguistic development. Language differences and dislocation experiences influence all aspects of development that are being assessed.
- Include collateral information from significant adults.

Comprehensive

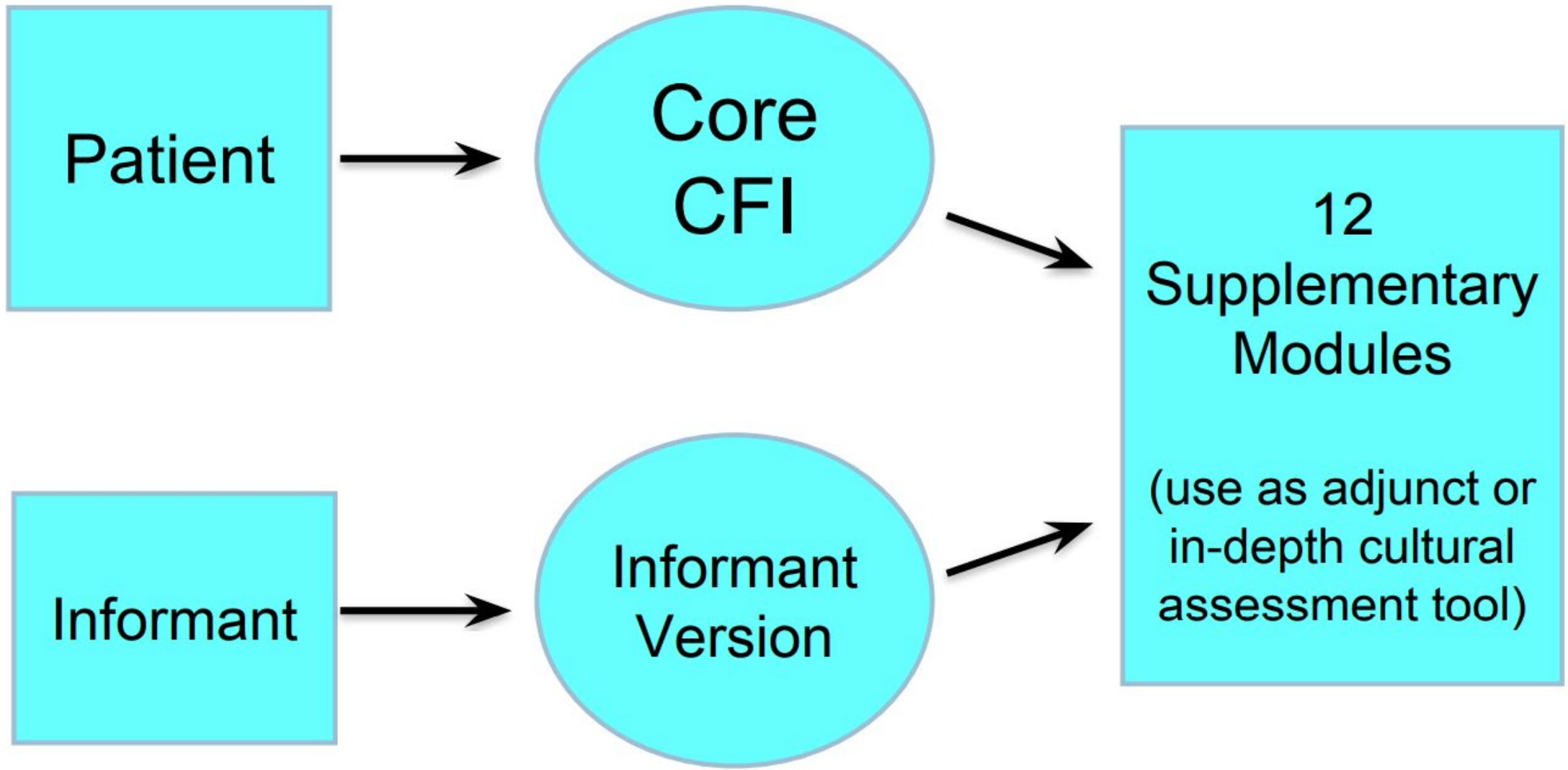
Thorough

Standardized

Skills-based

Person-centered

Educational


Patient
Core CFI
Informant
Informant Version
12 Supplementary Modules
(use as adjunct or in-depth cultural assessment tool)

CULTURAL DEFINITION OF PROBLEM

A. Definition of Problem
1. Own definition
2. How describe to social network
3. Most troubling aspect

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

B. Causes
4. Cause of problem
5. Cause per social network

C. Stressors and Supports
6. How environment is supportive
7. How environment is stressful

D. Role of Cultural Identity
8. Key aspect of background or identity
9. Effect on problem
10. Other concerns re cultural identity

CULTURAL FACTORS AFFECTING COPING AND HELP SEEKING

E. Self-coping
11. Methods of self-coping

F. Past help seeking
12. Help seeking from diverse sources

G. Barriers
13. Barriers to obtaining help

CURRENT HELP SEEKING

H. Preferences
14. Most useful help at this time
15. Other help suggested by social network

I. Clinician-Patient Relationship
16. Concerns about misunderstanding affecting care

Video/Text Examples of CFI In Action

- https://www.youtube.com/watch?v=8SjBG9di8ss
- https://www.youtube.com/watch?v=Nwy0WaKILDQ

- https://multiculturalmentalhealth.ca/wp-content/uploads/2019/07/CFI-School-Age-Children-and-Adolescents_REV1.pdf

Goals of Incorporating Cultural Humility into Mental Health

- Medicalization vs. Contextualization
  - Understanding POV, suffering; framing problems and solutions; build relationships
- Recognition of Health Disparities (frontier mental health!) and barriers to care (and possible solutions)

Clinical Vignette

- Adil is a 14-year old Muslim refugee who arrived in the United States 2 months prior to his admission to an impatient psychiatric unit after attempting to stab himself. This suicide attempt occurred after he learned that his betrothed had been kidnapped for a ransom. Adil neither speaks nor understands English; he is fluent only in his native tongue, for which there is only one interpreter within a 3-hour radius of the hospital, with limited availability. There only video interpreter speaks a related language which Adil does not speak fluently.
- Treatment: through the appropriate interpreter, we were able to appropriately understand the level of frustration he felt about his inability to help his family and fiancée. We were able to understand his traumatic experiences, cultural and linguistic barriers with his family and school, and his sense of isolation as no one had offered him a Qur'an or access to services. Once he learned that his fiancée has been rescued, his suicidal thoughts subsided and he was able to be discharged safely with recommendations for improving the environment for him in his foster family.

Advocacy

- Leadership—use your voice!
- Shortage of providers—every voice matters!
- Increased use of technology—potential to expand care, but how to make this equitable, just, and therapeutic.
- Changing regulations, laws
  - Challenges between state and federal expectations
  - Using resources to navigate some of these challenges
- DEIB in your place of work—be a change agent.

Clinical Vignette

Martin is 14yo, 8th Grader with history of ADHD referred for mood dysregulation and recent school suspensions for aggression. Concerns raised if he has ASD. Martin is cared for my MGM and lives in small community where most people live below the poverty level and resources are scarce. The referral clinic has contracted out telepsychiatry.

Treatment: Telepsychiatrist notes a connection between Martin and local clinical nurse who serves school district. They have good rapport despite Martin's poor eye contact and tendency to change subject. MGM acknowledges that Martin needs help if he is going to be successful but acknowledges that technology is new to her having just recently obtained WiFi and a smart phone.

Clinical Vignettes

Andrea is a 12 yo girl born in NYC, family is from El Salvador. She has two siblings (younger brother born in NYC with ASD; older sister who is a “Dreamer”). Her parents are undocumented. Andrea’s family is like many “mixed-status” families, with children and parents of different immigration status living together in the US.

Andrea is a good student and wants to be a doctor when she grows up. She becomes increasing anxious because of immigration raids in nearby communities and negative media messages about immigrants. She worries about what will happen to her and her siblings if her parents are deported. Andrea begins having trouble eating and sleeping. Andrea’s teacher recommends that she meets with the school therapist because she has appeared sad and distracted during classes and her grades have started to decline.

Clinical Vignettes

Treatment:

- The school therapist knew that culturally appropriate care and treatment in Spanish was critical for Andrea and her family. She began using narrative therapy with Andrea and later included conjoint sessions with her family.
- The therapist also connected the family with a family navigator or case manager who helped them address essential needs, connecting the family to social services, health care, and legal resources for addressing immigration issues.

Thank You!