
The Lunch Date

Lunch Date Discussion

Introduction to Cultural Competence

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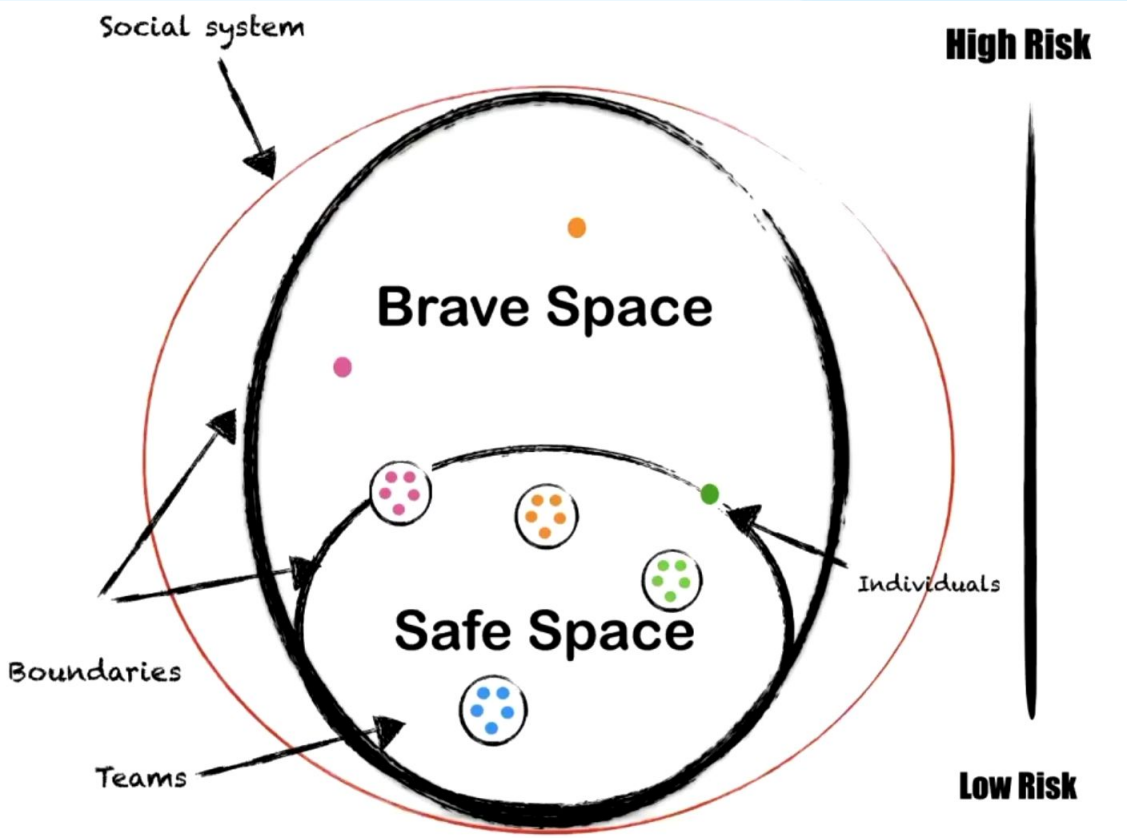
Learning Objectives:

- Understand the need to consider culture in therapeutic relationships
- Recognize the impact cultural identity can have on patient provider interactions
- Discuss and complete the Implicit associations test on race
- Learn about the Cultural formulation interview (CFI)
- Practice the CFI questions

Group Rules - Reminder

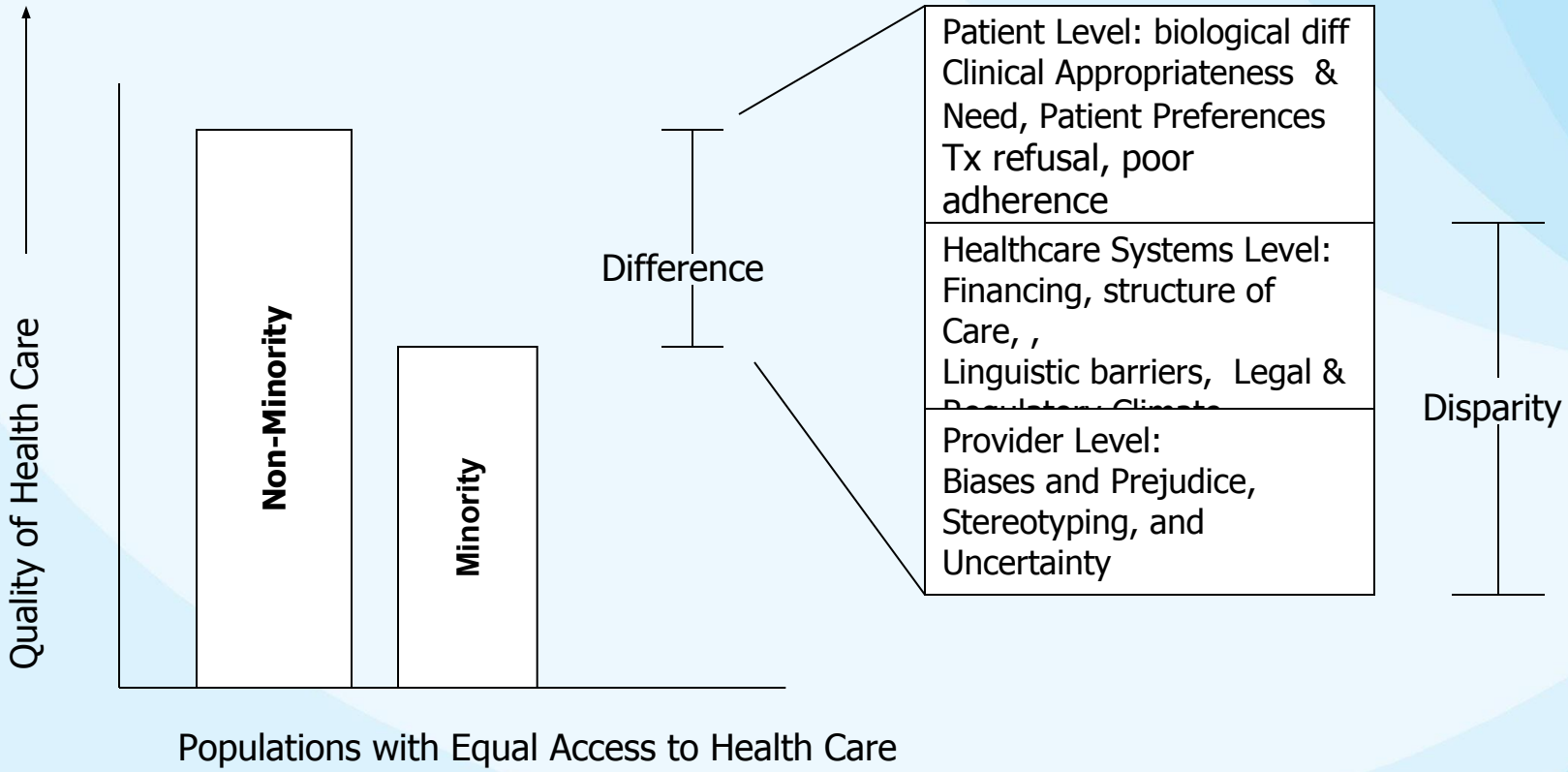


Culture

- Culture not only race, language
- Culture = what colors your lens
- Both Patients and their providers

Source: Kleinman & Bronson (2006)

Why Does Cultural Awareness Matter?



Adapted from: Gomes and Mcguire (2001)

Implicit bias is pervasive but it is challenging to find people willing to acknowledge and confront them when they harm others.

Implicit Associations Test

Implicit biases and the healthcare professional

Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review

(Hall, Chapman, Lee, Merino, Thomas et al., 2015)

- Implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes.
- Implicit attitudes were more often significantly related to patient–provider interactions and health outcomes than treatment processes.

Implicit Associations Test & Discussion

https://implicit.harvard.edu/implicit/takeatest.html


BACK IN
5
MINUTES

Implicit Association Test (IAT)

- Developed by Greenwald, McGhee, and Schwartz in 1998 to measure implicit cognitions and overcome reliability of self-report measures (Greenwald et al, 2009)
- The Implicit Association Test (IAT) is often used to measure implicit biases with regard to race, gender, sexual orientation, age, religion, and other topics.
- Project Implicit : now has over 90 different topics
- Not without controversy
- Does this predict behavior?
- Emotions not stereotypes???
- How we can use this data

Implicit Association Test (IAT)

- Score is based on how long it takes a person, on average, to sort the words in the third part of the IAT versus the fifth part of the IAT.
- While your results are unlikely to change dramatically from test to test, some variation is to be expected
- Your IAT results may be influenced by factors related to the test (e.g., the category labels or images/words used to represent the categories on the IAT) or factors related to the person taking the test (e.g., how tired you are, what you are thinking about).
- Classic research in psychology shows that people tend to like things that they are familiar with. So, there may be a role for familiarity in liking of the categories. But also people avoid things that they don't like, so it is possible that implicit bias is what leads to unfamiliarity.
- About a third of Black participants show an implicit preference for White people relative to Black people which can't be explained as an ingroup bias. In addition, there are plenty of tests on which people prefer one group or the other even when they do not belong to either group. For example, Asian participants tend to show an implicit preference for White people relative to Black people. In this sense the IAT might also reflect what is learned from a culture that does not regard Black people as highly as White people.
- Many people use the word 'prejudice' to describe people who report negative attitudes toward social groups. By this definition, most people who show an implicit preference for one group (e.g., White people) over another (e.g., Black people) are not prejudiced. The IAT shows biases that are not necessarily endorsed and that may even be contradictory to what one consciously believes. So, no, we would not say that such people are prejudiced.

Disparities in the Clinical Encounter: The Core Paradox: Possibilities examined

- Bias – no evidence suggests that providers are more likely than the general public to express biases, but some evidence suggests that unconscious biases may exist
- Uncertainty – a plausible hypothesis, particularly when providers treat patients that are dissimilar in cultural or linguistic background
- Stereotyping – evidence suggests that providers, like everyone else, use these 'cognitive shortcuts'

Disparities in the Clinical Encounter Stereotyping: A Definition

- Process by which people use social categories (e.g. race, sex) in acquiring, processing, and recalling information about others.
  - Automatic
  - Unconscious process

Stereotyping beliefs may serve important functions - organizing and simplifying complex situations and giving people greater confidence in their ability to understand, predict, and potentially control situations and people.

Disparities in the Clinical Encounter Stereotyping: Risks

- Can exert powerful effects on thinking and actions at an implicit, unconscious level, even among well-meaning, well-educated persons who are not overtly biased.
- Can influence how information is processed and recalled.
- Can exert "self-fulfilling" effects, as patients' behavior may be affected by providers' overt or subtle attitudes and behaviors.

Disparities in the Clinical Encounter Stereotyping: When Is It in Action?

- Situations characterized by:
  - Time pressure,
  - Resource constraints, and
  - High cognitive demand,
  - Need for quick judgements
  - Complex Tasks
  - Anger or anxiety

promote stereotyping due to the need for cognitive 'shortcuts' and lack of full information.

Source: Van Ryn, 2002

Exercise

- Patient scenario- The vaccine

Culture

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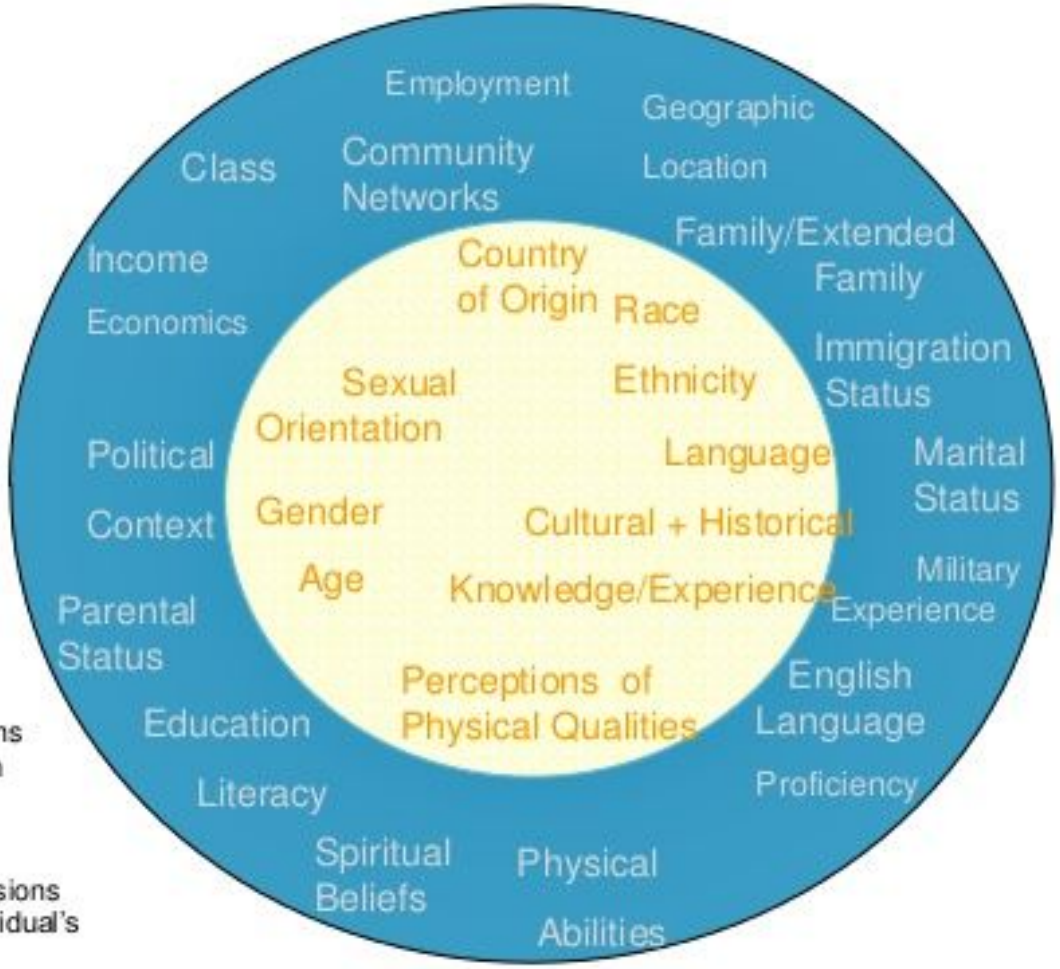
Source: Kleinman & Bronson (2006)

Cultural Considerations: Primary and Secondary Dimensions of Diversity



Primary dimensions influence "who" an individual is.

Secondary dimensions influence an individual's participation.

(adapted from Rasmussen, 1996)

Cultural Competence

- Supersedes cultural differences,
- Establishing Effective relationships.
- Considering Social and Cultural factors
- Influences planning recommendations appropriately

Term competence can be problematic: implies process is reducible to a technical skill.

Source: Beach Et al (2005)

Cultural Competence Essentials of the Journey

- Self assessment of one's own cultural identity, values, prejudices, biases,.
- Humility about the limits of one's assessment and treatment knowledge/skills
- Valuing diversity via awareness of and sensitivity to cultural differences
- Vigilance towards the power dynamics that result from cultural differences
- Responsiveness to cultural differences via adaptation of assessment and treatment

Source: Frances Lu

Cultural Humility

- The ability to maintain an interpersonal stance that is other-oriented, in relation to aspects of cultural identity that are most important to the client (or supervisee) (Hook, J. et al 2016)
- Other-oriented = what is important to the other person? How do they see/explain the world?
- *Honest curiosity* that is modeled in inviting the patient to share their cultural identity

Research on Cultural Humility

- Research has found cultural humility as a desirable quality in therapists and supervisors
- It has been positively related to client improvement and adherence to treatment
- Fosters strong therapeutic alliance
- Culturally humble clinicians view themselves as always being in the process of multicultural learning

Impact on Treatment

- Helps to know: how does the client's cultural identity impact their symptoms?
- How does it impact the way they present it?
- How our own cultural identity impacts our understanding of the symptoms/ presenting problem?
- All treatment relationships are cross-cultural; none of us share all the same identities

"unless we routinely examine the operations of power and our place within these operations, we fail to notice how we are liable to inadvertently impose our expectations, our cultural ways, our ways of thinking, on the people with whom we work."

Salome Raheim (2012)

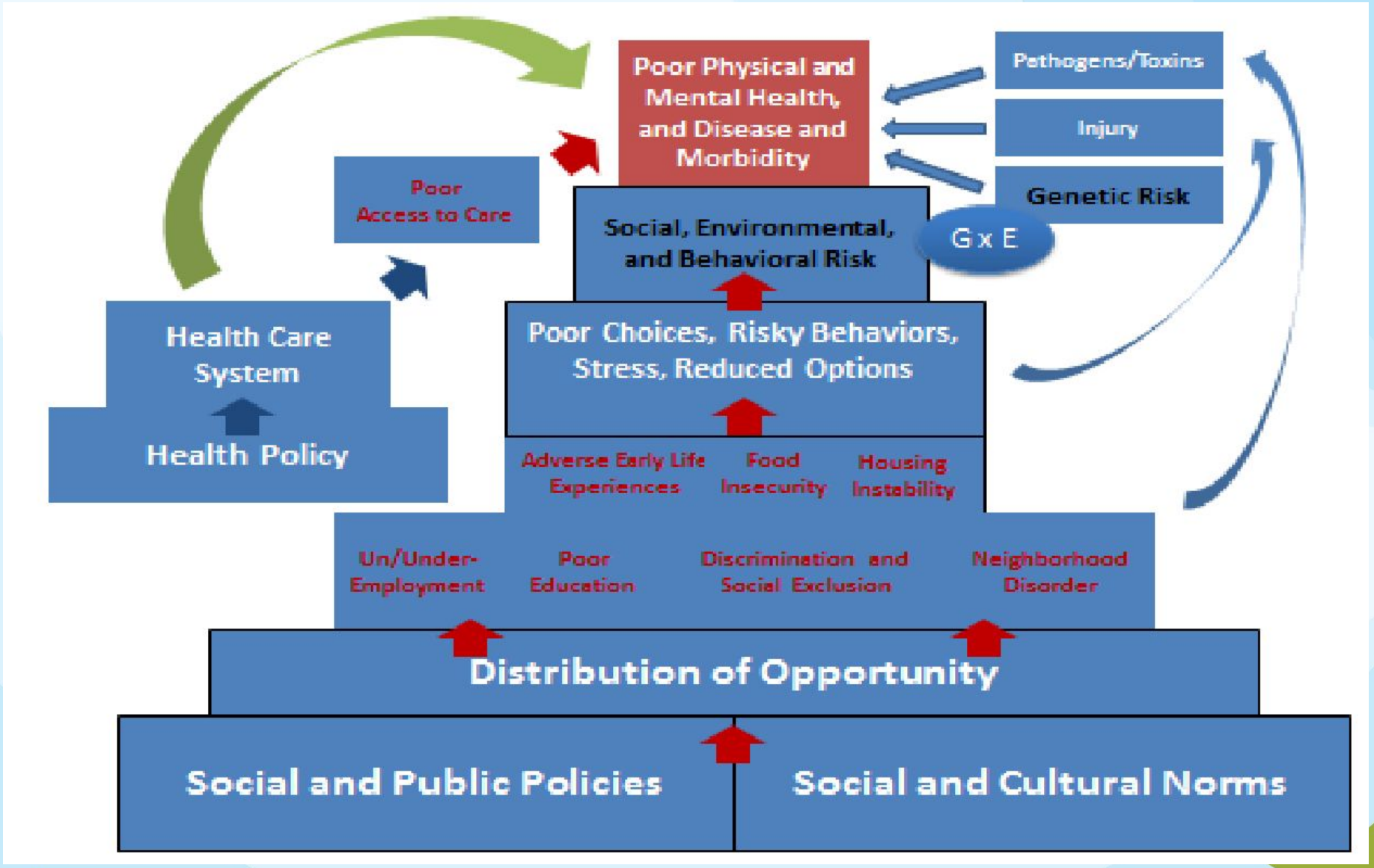
Prominent Causes of Health Disparities And Inequities

Social Determinants are major contributors to:

Health disparities: differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities

Health inequities: disparities in health that are a result of systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity

Architecture of Risk



Provider Biases and Stereotypes in the Clinical Encounter

- van Ryn and Burke (2000)
- Finucane and Carrese (1990)
- Rathore et al. (2000)
- Abreu (1999)

Summary of Findings

- Racial and ethnic disparities in health **care** exist and, because they are associated with worse outcomes in many cases, are unacceptable.
- Many sources –health systems, health care providers, patients, and utilization managers – contribute.
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare.
- Differences in refusal rates between Racial and ethnic minority patients and white patients are generally small, and minority patient refusal does not fully explain healthcare disparities.

DSM 5 Cultural Formulation Interviews

Cultural Formulation Interview

- DSM IV- Outline for Cultural Formulation (OCF)
  - Identity
  - Explanatory model or cultural explanation of illness
  - Cultural factors: family and social support
  - Cultural elements of clinician patient relationship
  - Overall impact of culture on diagnosis and care

- DSMV – Cultural Formulation interview (CFI)

Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM (Explanatory Model, Level of Functioning)	
Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?

Emphasis on Cultural Humility

Cultural Formulation Interview Main Themes

CULTURAL DEFINITION OF THE PROBLEM

People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would **you** describe your problem?

CULTURAL PERCEPTIONS OF CAUSE CONTEXT AND SUPPORT

Is this the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes?

Explore Supports

CULTURAL FACTORS IN SELF COPYING AND HELP SEEKING

People have various ways of dealing with problems. What have you done on your own to cope with your [PROBLEM]? And in the Past? What type of help was most useful?

Any **Barriers?**

CULTURAL FACTORS IN CURRENT HELP SEEKING

What do you think would be most useful to you at this time?

Definition of the "Problem" (Domain 1)

1. Describe your problem
2. Describe to you social network
3. Most troubling

Causes Stressors and Supports (Domain 2)

4: Cause of problem
5: Cause according to social network
6: How supportive is environment
7: How stressful is environment is
8: Key aspects of background or identity
9: Effect on problem or condition
10: Other concerns regarding cultural identity

Cultural Factors Affecting Coping & Help Seeking **(Domain 3)**

11: Methods of self-coping Past help-seeking
12: Past help seeking from diverse sources
13: Barriers to obtaining help

Current Help Seeking (Domain 4)

14: Most useful help at this time

15: Other help suggested by social network

16: Misunderstanding and how to provide care Have you been concerned about this and is there anything that we can do to provide you with the care you need?


BACK IN
5
MINUTES

CFI Questions Summary

How do you **call** it and

what do you think is the **cause**

Stressors and supports - **social determinants**

Role of cultural identity

Self **coping** and past help

Barriers to help

Current **wishes** and preferences for help

Differences between provider and patient

Interview Practice

- Pair up- break out rooms
- choose a case to role-play
- Role Play with group
- pair discusses experience
- group feedback

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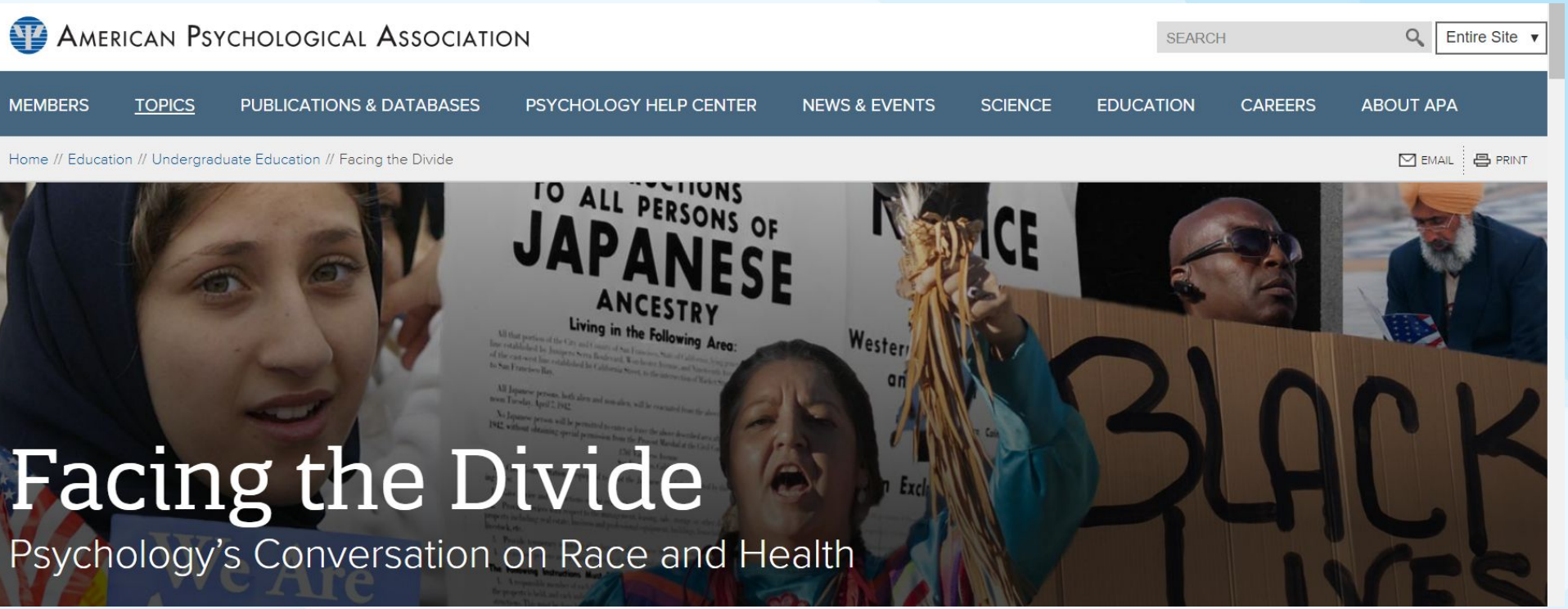
Questions & Final Thoughts

Health Care Disparities further explored

2012 Resident Grand Rounds Yale Psychiatry Department

2020 Juneteenth at CHC

APA Racism Video



Take the test again:

https://implicit.harvard.edu/implicit/takeatest.html