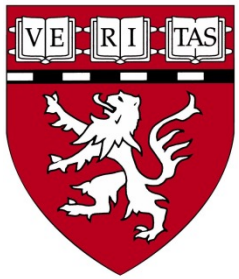
Culturally Informed Strategies Working with Diverse Patients with Mental Illness

Martin J. La Roche, Ph.D.

Martin.laroche@Childrens.Harvard.edu

Boston Children's Hospital at Martha Eliot



New England (HHS Region 1)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Housekeeping Information

Participant microphones will be muted at entry

If you have questions during the event, please use the chat

This session is being recorded and it will be available by the next business day.

Information about certificates of completion will be sent in a follow-up e-mail

If you have questions after this session, please e-mail: newengland@mhttcnetwork.org.

At the time of this presentation, Dr. Miriam E. Delphin-Rittmon served as SAMHSA Assistant Secretary. The opinions expressed herein are the views of the moderator and panelists and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

This work is supported by grant #1H79SM081775 from the DHHS, SAMHSA.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

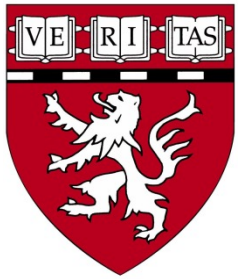
Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Culturally Informed Strategies Working with Diverse Patients with Mental Illness

Martin J. La Roche, Ph.D.

Martin.laroche@Childrens.Harvard.edu

Boston Children's Hospital at Martha Eliot

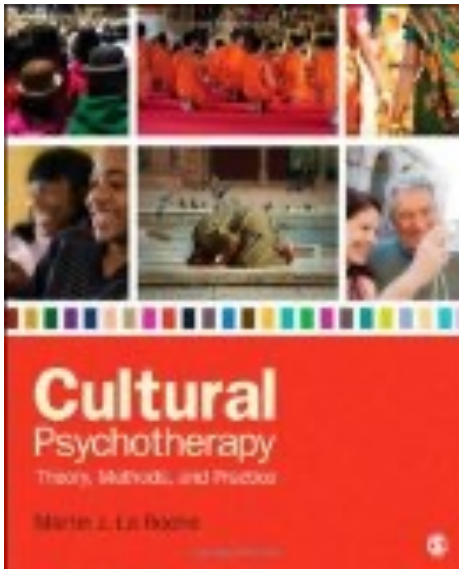


New England (HHS Region 1)

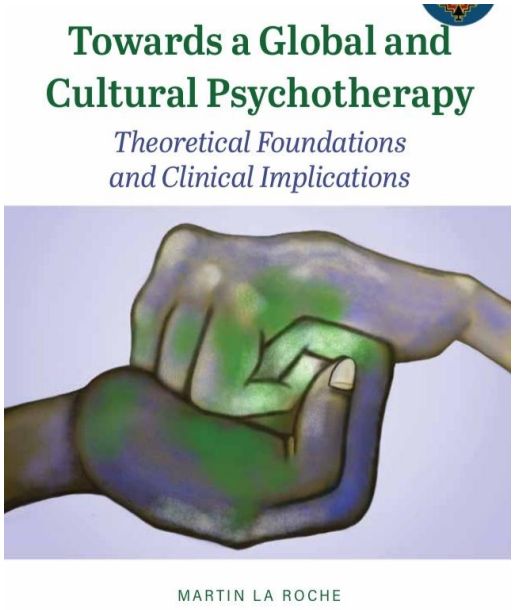
MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Disclosure



I have published two books and have DVD from which I receive royalties



The main goal of this talk:

To suggest ideas that can refine the accuracy of our mental health assessments by considering cultural/global meanings and context(s), particularly with diverse patients with mental health illness.

What is a mental health assessment?

Mental health assessments are a systematic process in which an accurate portrayal of the other (patient/client) is sought. It requires information that is objective (reliable/valid) through a constellation of symptoms that allows us to arrive to a specific diagnosis

Components of mental health assessments

- Chief Complaints
- History of Problems
- Mental Status
- Diagnosis
- Biopsychosocial Formulation
- Treatment plan

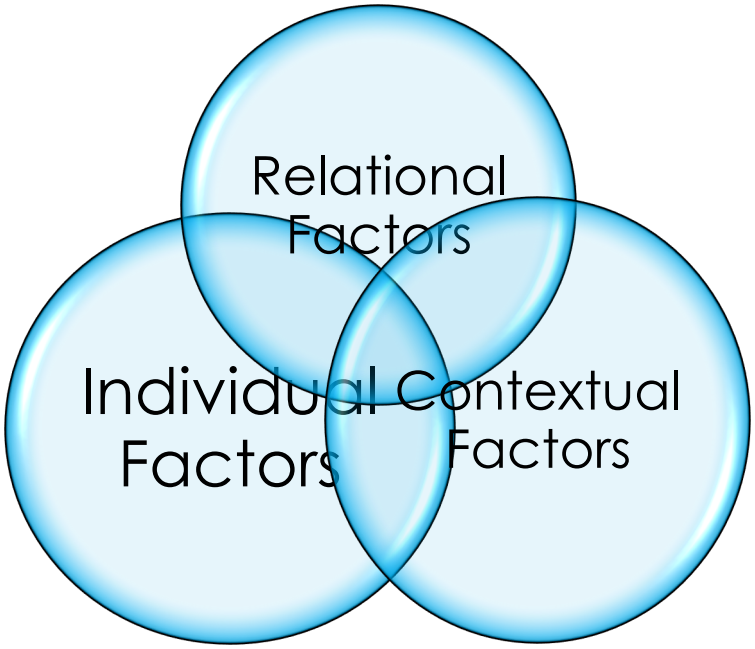
Three sources information that influence assessments

1) Individualistic Factors: The characteristics that reside within the client/patient being assessed

2) Relational Factors: The effects of the interpersonal relationship established between patients and therapists. Includes the influence of the clinician (e.g., cultural biases, level of competence) on the assessment process.

3) The cultural/global factors: The place and time in which the assessment occurs permeates what is said (or not) and how it is understood. It also includes the clients and patients' cultural meanings.

Global and Cultural Psychotherapy Model: Factors are not independent



Characteristics of global/cultural Influences

The basic assumption of global and cultural psychotherapy is that the place and time in which the psychotherapeutic process unfolds- in addition to individualistic and relational ingredients- impacts what is said (or not), what is understood and/or what is done within the assessment and/or psychotherapeutic process. Not knowing cultural/global influences limits our ability to have an accurate understanding of the other.

Characteristics of global/cultural Influences

Culture shapes every aspect of clinical care, influencing when, where, how, and to whom patients narrate their experiences of illness and distress (Kirmayer, 2006).

Both the patterning of symptoms (Kleinman 1977) and the models clinicians use to interpret and understand symptoms are reflective of their own cultural beliefs.

Clients and clinicians' differing cultural conceptions can lead to misunderstandings and misdiagnosis.

Assessment Issues: Cultural differences can be misconstrued as deficits!

1) Racial/ethnic minorities, refugees, and different culturally diverse (e.g., Muslims, GLBTQ) groups have traditionally been overpathologized. It is difficult to differentiate what is pathology and what is a cultural difference.

2)There are multiple ways of being, there is much diversity amongst cultures and individuals within each group. Many of our assumptions of what is correct/healthy are based on White Middleclass values and skills that are necessary to compete in our global market.

3) Our global/cultural context defines what is normal and pathological. It is not only important to understand where patients come from but also their immediate contexts (neighborhood violence, poverty, gangs) and cultural meanings. Many of our expectations are based on norms that are culturally defined.

4) Global/cultural psychotherapy attempts to make these implicit cultural meanings explicit so that they will not inadvertently bias our assessments.

Some prevalent Western-American Values that can influence assessments

1)Rugged Individualism

1.1) The individual is the primary unit of analysis (i.g., independence and autonomy).

1.2) Cultural expecations vary in regads to a child's age of separation from parents, when they are toilet trained, etc.

1.3) Not having clear boundaries between self and others is pathological (e.g., enmeshment, inmaturity).

2) Competition

2.1) Winning is everything (e.g., win or lose dicothomy)

2.2) Collaboration is often not valued sufficiently.

3) Action/Time Orientation

3.1) Must master and control nature and situations very quickly

3.2) Pragmatic/utilitarian view of life

3.3) Being passive, dependent and submissive it is considered pathological

Some prevalent Western-American Values that can influence assessments

4) Family Stucture

- 4.1) Nuclear family is the ideal social unit
- 4.2) The father is usually the breadwinner
- 4.3) The mother is the homemaker and the head of the household

5) Gender Roles and identity

- 5.1) Patriachal power structure
- 5.2) Clearly defined and rigid gender roles

6) Language

- 6.1) Language conveys emotional meanings that may not be translatable
- 6.2) Language match decreases treatment drop out rate.
- 6.3) Language shift

Kleinman's (1988) Eight Questions: Outline of the Cultural Formulation (OCF)

1) What are they calling the problem(s)?
2) What do they think caused the problem(s)?
3) Why do they think the problem(s) started when it/they did?
4) What do they think the problem(s)/sickeness does/do?
5) How severe are the problem(s)? Will they have short or long course?
6) What kind of treatment(s) do they think they should receive to get better?
7) What are the chief problem(s) the sickness has caused?
8) What do they fear the most about the problem(s)/sickness?

Cultural Formulation Interview (CFI)

1) The Cultural Formulation Interview (CFI) was first introduced in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, APA, 2013), pp 749-757.
2) The CFI is an updated and revised version of the Outline of the Cultural Formulation (OCF), which, was first described in an appendix of DSM-IV (APA, 1994).
3) The objective of the CFI is to identify cultural and contextual factors relevant to the diagnosis and treatment of different problems; it aims to understand patients' symptoms and world's views by more accurately examining them in relationship to their cultural context.
4) The underlying assumption of the CFI is that culture shapes every aspect of clinical care, influencing when, where, how and to whom patients narrate their experiences of illness and distress (Kirmayer, 2006). The patterning of symptoms (Kleinman 1977) and the models clinicians use to interpret and understand symptoms in terms of psychiatric diagnoses (1987) are reflective of these cultural beliefs.

Cultural Formulation Interview

5) The CFI is much more structured and even manualized than the OCF; it is an excellent research tool.

6) Two versions of the CFI are available, one for the individual or patient and a CFI-Informant version (e.g., parents).

7) In addition, both the CFI and CFI-Informant versions can be complemented by one or several of the12 Supplementary Modules that address specific areas of interest/concern.

8) Each of these 12 modules provides additional and more detailed questions to assess specific domains briefly explored in the 16-item CFI (e.g., cultural identity) as well as questions that can be used during the cultural assessment of particular groups, such as children and adolescents, older adults, immigrants and refugees, and caregivers.

9) The individual direct assessment is not very helpful for youth under 12; it is preferable to use the CFI-informant version with the child's parents, teachers, etc.

The four areas of the CFI

The CFI explores the following four areas:

1) Cultural definition of the problem (e.g., what brings you here using the individual's vocabulary).
2) Cultural perceptions or understanding of the cause(s) of the problem (e.g., why do you think this is happening to you) which includes two subsections stressors and supports and role of cultural identity.
3) Cultural factors affecting self-coping and past help-seeking.
4) Cultural factors that could improve treatment (e.g., what kind of help do you think would be most useful to you at this time). Preferences and the therapeutic alliance.

A) Cultural Definition of the problem(s)

Explanatory Model, Level of Functioning (Cultural definition of the problem(s).

1) What brings you here today?

2) Sometimes people have different ways of describing their problem(s) to their family, friends, or others in their community. How would you describe the problem to them?

B) Cultural perceptions of the causes of problems

B) Cultural Perceptions of Cause, Context, and Support (Causes)

3) What troubles you the most about the problem(s)?

4) Why do you think this is happening to you? What do you think the causes of the problem(s) are?

5) What do others in your family, your friends, or others in your community think is causing the problem(s)?

Focus on the views of the members of the individual's social network. These may be diverse and vary from the individual's.

B.2) Stressors and supports

B.2) Stressors and supports

6) Are there any kinds of supports that make your (PROBLEMS) better such as support from your family, friends or others.

Elicit information on the individual's life context, focusing on resources, social supports and resilience. May also probe other support from co-workers, from participation in religion.

7) Are there any kinds of stresses make your (PROBLEMS) worse, such as financial difficulties or family difficulties?

Role of Cultural Identity

B.3) Role of Cultural Identity.

8) For you, what are the most important aspects of your background or identity?

Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor question 9-10 as needed.

9) Are there any aspects of your background or identity that make a difference to your PROBLEM(s)?

10) Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

Self-Coping and Past Help Seeking

Cultural Factors Affecting Self-Coping and Past Help Seeking.

C.1) Self-Coping

11) Sometimes people have various ways of dealing with problem(s). What have done on your own to cope with your problem(s)?

C.2) Past Help-seeking

12) Often people look for help from many different sources, including different kind of doctors, helpers, healers. In the past what kinds of treatment, help, advice or healing have you sought for your problem(s). What types of treatment were the most useful or not useful?

Self-Coping and Past Help Seeking

C.3) Barriers: Clarify the role of social barriers to help seeking, access to care and problems engaging in previous treatment.

13) Has anything prevented you from getting the help you need?

- Probe as needed. For example, money, work, or family commitments, stigma or discrimination or lack of services that understand your language or background.

Cultural factors affecting current help seeking

Cultural Factors affecting Current Help Seeking

D.1) Preferences

14 Now let's talk some more about the help you need. What would be helpful for your problem(s)?

Clarify individual's current perceived needs and expectations of help, broadly defined.

15) Are there other kinds of help that your family friends or other people have suggested that would be helpful for you now?

Focus on the views of the social network regarding help-seeking.

Cultural factors affecting current help seeking

D.2) Clinician-Patient Relationship

16) Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Have you ever been concerned about this and is there anything that we can do to provide you with what you need?

Elicit possible concerns about the clinic or the clinician patient relationship, including perceived racism, language barriers or cultural differences that may undermine goodwill, communication or care delivery. Probe as needed in what way?

Translating the OCI & CFI into the assessment process

- Chief Complaints
  - What brings you here? (CFI 1-2)
  - What are they calling the problem (OCF 1)
- History of Problems
  - Why are they thinking they started when they did (OCF 3)
- Mental Status
  - What are they thinking the problem(s) does (OCF 4)
- Diagnosis
- Biopsychological Formulation
  - What are they thinking caused the problem(s) (OCF-2)
  - Cultural perceptions of cause, context, and support (CFI 3-7)
- Treatment plan
  - What kind of treatments are they thinking they should receive to get better (OCF 6)
  - Self-Coping, Past Help-Seeking & Barriers (CFI 11-16).

Miscellaneous issues about Culture and Severe Mental Health Illness

1) In this presentation severe mental illness refers mainly to psychosis and prodromal syndrome.

2) Severe mental health illnesses often represent a tragedy for those afflicted, for family members it is a source of sorrow, and a costly public health concern, however, its meaning varies from culture to culture.

3) Biology plays a central role in the etiology of psychosis –which leads some to talk about it as universal- but the way it is expressed, identified and treated is significantly shaped by culture.

4)Accurate identification of individuals in the earliest symptomatic stages of psychoses offers perhaps the best hope for effective treatment. Nevertheless, the rate of identification amongst racial/ethnic minorities remains significantly lower than that of Whites.

Miscellaneous issues about Culture and Severe Mental Health Illness

5) In general, individuals who have closer family members with more severe psychosis also have a greater risk of having psychosis. The way people identify and describe family and "symptoms" varies from culture to culture.

6) Psychopharmacological treatments are essential for the treatment of psychosis, nevertheless the way psychopharmacological treatment are construed vary culturally, which affects both treatment adherence and efficacy.

7) Severe mental illness is often accompanied by much comorbidity (e.g., anxiety, depression) which makes it more difficult to differentiate from other conditions .

Miscellaneous issues about Culture and Severe Mental Health Illness

8) The prevalence of psychotic like experiences (e., g, perceptual abnormalities, mild delusional thoughts) is estimated to be approximately 6% to 10% in the general population which complicates its identification. Nevertheless, it is more common amongst racial/ethnic minorities.

9) There are very useful questionnaires to measure severe mental illnesses, and some have been validated with different racial/ethnic groups for example, the Prodromal Questionnaire–Brief Child Version. (2011). Loewy RL, Pearson R, Vinogradov S, Bearden CE, Cannon TD.

10) There is much stigma associated with severe mental health illness. Many patients with psychotic symptoms –and their families- do not accept that they have a mental illness, which makes it difficult to engage in interventions of any kind. Part of this treatment reluctance is exacerbated by the inequities in treatment that have been noted among cultural groups in different countries

Early signs of psychosis (Prodrome Phase)

1) Difficulty screening out distracting information and sensations.

2) Difficulty focusing or understanding what they are hearing

3) Changes in perceptual experiences – visual experiences may become brighter or sounds louder

4) Feeling overloaded

5) Finding it harder to keep track of what they are thinking and what others are saying.

6) Feeling disconnected

7) Desire or need to be alone

8) Sleep disturbances

9) Depressed mood

10) Irritability

11) Suspiciousness

12) Unexplained difficulty at/skipping school or work

Why use the CFI in cases of Severe Mental Illness?

It increases engagement and accuracy in the assessment saving time/money and decreasing human pain.

The CFI appears to facilitate the emergence of a rule-governed reasoning process that involved three steps:

1) Problematize the diagnosis of the intake 'psychosis' symptoms or behavior.
2) Elaborate explanations as to why the symptoms or behavior may or may not be psychosis.
3) Confirm the diagnosis of psychosis or re-interpret as non-psychosis.

Some Integrative Cultural Factors to Keep in Mind

1) The stigma of mental health leads some to social isolation and hesitancy/mistrust in the utilization of available services/resources.

2) Being of a different race/ethnicity can entail having experienced much racism/discrimination and as result many can be more vigilant to further slights. Avoid coercion.

3) Poverty can exacerbate stress, hopelessness, depression and less access to resources, etc in sum more vulnerability to mental health disorders.

4) Consider patients' cultural identity (e.g., self-construal, gender roles) and how it could be impacting treatment.

5) Many who have immigrated have an extensive history of trauma.

Cultural Tips to work with Mental Illness

(1)Determine the need for an interpreter. Employing family members as interpreters should be avoided.

2)Allow extra time for linguistically or culturally diverse patients. Longer appointments can prevent the dissatisfaction and errors caused by too-rapid consultations. Scheduling extra time for first meetings (up to 2 hours if interpreters are involved)

3)Identify priorities. Migrants and refugees with psychosis face urgent practical problems whose resolution may need attention before standard care. Often case management is invaluable.

4) Cultural brokers are helpful to inform diagnosis/treatment. Cultural consultation is an approach that gives due regard to the role of culture in the diagnosis and treatment of individuals and families in local context.

Cultural Tips to work with Mental Illness

5)Cultivate cultural humility. Clinicians may be tempted to assert the supremacy of mental health models in assessing and treating psychosis. Instead, a more curious attitude towards religious beliefs and practices can identify assets and valuable community supports.

6)Adopt a flexible approach. Immigrants and refugees may unwittingly seek help or conduct themselves in ways that is "unique" in their new country. Examples include missing or arriving late to appointments; misunderstanding the purpose of consultations; forgetting medical insurance and other important papers; bringing children to evaluations; rejecting.

7) Psychoeducation is helpful particularly if it is tailored in cultural-sensitive manner.

Cultural Tips to work with Mental Illness

8)Be self-reflective. Clinician biases, assumptions, and prejudices rooted in majority cultures negatively impact patient outcomes.

9)Engage families. Promoting family involvement will facilitate positive outcomes in psychosis. Patients, their families and clinicians can explore solutions that are acceptable to their beliefs and values.

10)Consider alternatives to a psychosis diagnosis. When in doubt, clinicians should start with a diagnosis of mood disorder with psychotic features to counteract the known tendency of over diagnosing schizophrenia in minority clients. Alternative diagnoses to rule out include PTSD, dissociation, and culturally normative short-lived religious experiences

Selected references

Kleinman, A. (1988). *The illness narratives: Suffering, healing, & the human condition*. New York: Basic Books.

La Roche, M. (2019). *Towards a global and cultural psychotherapy: Theoretical foundations and clinical implications*. San Diego, CA Cognella Press.

La Roche, M & Bloom, J. (2018). Examining the effectiveness of the cultural formulation interview with children: A clinical illustration. *Journal of Transcultural Psychiatry*, 1-16.

Lewis-Fernandez, R., Aggarwal, N., Hinton, D., Hinton, L., Kirmayer, L. (2016). *DSM-5 handbook on the cultural formulation interview*. Washington, DC: American Psychiatric Publishing.

Questions/Comments?

Upcoming Events:

To register, visit our website: www.mhttcnetwork.org/newengland

Certificates & CEUs

- All participants will receive a certificate of completion for attending today's session.
- We will e-mail instructions to all registrants about how you can take the content quiz and request your CEU.
    - We offer NAADAC, NBCC, and ASWB only.
    - Certificate of completion for all other certifications.

Contact Us

www.mhttcnetwork.org/newengland

newengland@mhttcnetwork.org

SAMHSA
Substance Abuse and Mental Health Services Administration

New England (HHS Region 1)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration