Current Clinical Psychiatry
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Ranna Parekh
Nhi-Ha T. Trinh *Editors*

The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health

Second Edition

Humana Press

Current Clinical Psychiatry

Series Editor

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Editors

The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health

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and communities for their love and support.

Ranna Parekh and Nhi-Ha T. Trinh

Foreword: Staying the Course During Times of Upheaval

Five years have passed since the previous edition of this book was released, but in some ways, it seems like a lifetime ago.

It is one of the great paradoxes of this moment in history that even as we in the medical community are making ever-greater strides toward understanding what it means to be culturally competent care providers, some people—leaders and citizens alike—want to go back to a time with less diversity and more divisions. They see our nation's diversity as a threat, not an asset. This dangerous perspective threatens our society, our healthcare system, and the mental health of the patients we serve.

It is certainly a serious setback that adds an extra layer of weariness and concern for mental health providers both seasoned and in training.

And it underlines the importance of the message of this book. Its goal is more critical than ever.

In 2014, I was rounding into my fifth year as chief diversity officer at the Association of American Medical Colleges. We had started to move past seeing diversity as a problem to be fixed to the realization that inclusion could serve as a solution to some of the most intractable issues in our healthcare system. Cultural competence had emerged as an important metric by which healthcare providers of all types are evaluated. Medical schools and residency training programs were making strides toward embracing diversity and inclusion to improve healthcare, advance health equity, and ensure effective and compassionate care for all patients, regardless of race, culture, gender, or sexual orientation. We had a long way to go, but many of us—myself included—saw positive signs that we were on the right track.

However, since the run-up to the 2016 US presidential election, both the scholarly and popular presses have reported that increasing numbers of Americans—many of whom belong to the groups discussed in the chapters of this book—feel increasingly unwelcome, worried, and anxious due to the increasingly xenophobic, divisive, and vitriolic nature of public discourse in this country. The acts of violence and aggression toward racial, cultural, and gender minorities are on the rise.

The healthcare system—and particularly mental health facilities—should be a refuge immune to this toxin. Patients of all races, ethnicities, genders, and countries of origin should have their unique needs, perspectives, and experiences understood whenever they interact with the healthcare system. Indeed, this is a necessary ingredient for quality care and a prerequisite for health equity.

And it is arguably even more important when diagnosing and treating mental illness.

Twin Tenets of Cultural Competence

Throughout my career, I have worked to advance diversity and inclusion among health professionals and in our healthcare system. I firmly believe that a more diverse healthcare work force is a necessary step toward health equity and opens the way for more compassionate and culturally competent care for all patients.

But truly embracing diversity, inclusion, and cultural competence goes beyond training providers from diverse backgrounds to “care for their own.” It requires ensuring that providers of all backgrounds have the skills and awareness to care for patients of all backgrounds. Health professionals must make the effort to understand where people come from, the experiences they bring, and the experiences they expect to have.

As American society becomes increasingly diverse culturally, ethnically, racially, and linguistically, we in medicine see twin tenets of cultural competence. First is the recognition that patients’ social and cultural influences affect their perceptions of and reactions to health, illness, and medical care. Second is the realization that providers must tailor their care appropriately based on the patient’s unique set of cultural needs and sensitivities.

Cultural competence also recognizes that no one exists in a cultural vacuum, including healthcare providers. Culturally competent healthcare providers have learned to acknowledge and examine the potential for unconscious bias that exists within all humans. We are all prone to making snap judgments or assumptions about people based on their superficial and group characteristics—unless we make a conscious effort to avoid them.

The beauty of this nation lies in the assimilation of *values*, not of cultures. We are not a melting pot so much as a rich mosaic of diverse and varied backgrounds, experiences, hopes, and dreams, tied together by a freedom to express our unique selves.

Cultural competence helps create the space for that to happen.

As in so many aspects of life, communication is the key. This goes beyond words to include actions, attitudes, and how we relate to patients. Culturally competent providers communicate sensitively and, without judgment, treat each person as the unique individual they are. They get to know patients, demonstrating their concern and compassion and—above all—explore the unconscious assumptions that might affect interactions.

In other words, the goal of reading this book and receiving cultural competency training in other ways should not be to help you make assumptions about your patients’ lived experiences but to listen to them more effectively—really listen to what they tell you about their own beliefs and experiences every day—in every encounter. We take important steps to understand how individuality (which includes race, culture, gender identify, and country of origin) influences healthcare needs when we take time to recognize subtle differences among us. For example, we can better meet the needs of all people when we do not lump all Asians, all Latinos, or all LGBT individuals into one category, no matter how culturally sensitive we are to that category.

That is the true goal of cultural competency: listening, caring, and considering our individual experiences while building on the many commonalities we as humans share.

You will not achieve this goal by reading a single textbook or sitting in on a training. Rather, it's a lifelong pursuit with a mind-set to "open."

Are you up to the challenge?

Marc Nivet
UT Southwestern

Preface

It's human nature to try to understand why distressing symptoms are occurring, such as sleep loss, anxiety, or thoughts of suicide, and to associate them with environmental or temporary circumstances, such as job stress or grief, when explaining to healthcare providers how they feel it's important to most patients to provide that context for symptoms. Context can include changes from baseline levels of functioning, events surrounding the onset or exacerbations of symptoms, and associated psychosocial difficulties such as family or financial problems. The filters through which patients interpret their symptoms will determine which they report and how severe they are perceived.

Culture defined broadly as a set of beliefs stemming from one's family, social, or national origin reference group also provides a context for how people interpret psychological, emotional, behavioral, and psychiatric symptoms. However, most people would not understand the importance of sharing such an explanation with clinicians when seeking help for their distress. Understanding cultural differences, listening for subtle cultural interpretations of symptoms, and knowing when to ask about them can guide clinicians' queries during diagnostic interviews and discussions around potential treatments, thus improving the quality of care.

The second edition of *The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health* provides culturally based conceptual frameworks and in-depth information on epidemiology, symptom presentations, and social contexts of mental illness in racial and ethnic groups, gender minority populations, and immigrant groups. Guidelines are provided for conducting patient interviews that reach beyond surface symptoms and help the clinicians avoid the mistake of relying on their personal cultural references as filters in clinical decision-making.

The breadth of topics makes this collection broadly useful by a range of practitioners—medical, legal, mental healthcare, and journalistic. The editor's careful selection of contributors reflects the view that professionals from a variety of disciplines can play a role in presenting to the public, especially those in need, a compassionate and unbiased representation of mental health that demonstrates an appreciation of individual differences.

In Chapter 1, guidelines are provided for training in cultural competence and implicit bias, including strategies for dealing with resistance. The methods for skill development, reshaping thinking patterns, and increasing self-awareness are provided as well as ways to address sensitive issues, such as privilege, white fragility, and coming to terms with one's own racism. The authors discuss challenges unique to vulnerable groups at the intersectionality of characteristics, such as race and gender or age and socioeconomic status.

Chapter 2 describes the value of cultural humility as an approach to interview patients. Humility is reflected in a posture of appreciation for differences among people and in the sincere desire to better understand those differences. Specific guidance is provided for ways to augment clinical interviews to gain a clearer understanding of how a person's cultural reference for health problem and treatment influences their interpretation of symptoms.

Chapters 3 and 5 provide insights from beyond the realm of mental healthcare. Chapter 3 on mediation and negotiation recognizes how men and women across the age spectrum differ in their comfort with asserting their will in these processes. As authors Hoffman and Triantafillou explain, "cultural competence involves more than freeing our minds of bias—it requires affirmatively seeking to understand the people we encounter in the mediation process and elsewhere." Guidance is offered for creating an comfortable atmosphere in the negotiation and mediation process for people from various demographic and cultural groups. Similarly, Chap. 5 on news reporting of mental health issues, especially in controversial circumstances such as mass shootings, provides guidance for cultural sensitivity and compassion in reporting. Excellent examples are included of how journalism has handled stories on mental health and how journalists have attempted to provide information about race and mentally illness that transcends stereotypes.

Chapters 4, 6, and 13 cover factors that can limit access to and use of medical care in immigrant populations beyond obvious language differences, such as stigma attached to mental illness and fear or mistrust of healthcare systems. The readers are provided with ways to evaluate how their own culture influences their approach to patient care. The authors emphasize the importance of considering broader issues of power, privilege, and structural inequality when working with migrant communities and advocate for cultural responsivity and intervention at the organizational, structural, and patient levels.

Chapters 7 through 11 are excellent reference chapters on mental health presentation, treatment, and sociocultural factors in health for specific populations, including people of African descent, American Indians, Alaska Natives, Arab Americans, Asians, and Latinos. Appreciation of how conceptualizations of mental health and illness vary across these groups can improve the accuracy of psychiatric diagnoses, the treatment selection, and the discussion of sensitive mental health issues with patients and their family members.

Chapter 12 provides a conceptual framework for working with people on the sexual and gender continuum. It encourages clinicians to think beyond binary labels and to consider gender identification, gender role and expression, sexual attraction, and sexual behavior as elements of sexual and gender identity. In their discussion of health problems unique to sexual minority populations, the authors encourage attention to the intersectionality with age, race, and socioeconomic status.

The chapters of this book focus primarily on mental health. However, it is an excellent reference book for clinicians in training across other areas of medicine. Guidance is provided for those who work in psychiatric settings, particularly those that serve multicultural communities, but is also applicable to those working elsewhere in the healthcare system. The authors effectively make the case that a richer understanding of differences across cultural groups can enhance the quality of care provided and the healthcare experiences of those in need. This guide for culturally sensitive and competent diagnostic evaluations and patient interactions sets the stage for developing strong therapeutic alliances and efficacious treatment plans.

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Quotation Page

"Darkness cannot drive out darkness: only light can do that. Hate cannot drive out hate: only love can do that."
Martin Luther King, Jr.

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Part I

Innovative Ways to Understand Diversity

Diversity Dialogue

1

Anne Emmerich, Ariel Otero, Ranna Parekh,
and Estee Sharon

Introduction

In professional life, the concept of cultural difference can take many forms. Each day an individual encounters people who differ in age, ethnicity, gender identity, health status, housing status, language, nationality, race, sexual identity, socioeconomic status, weight, etc. As a professional, one may be confronted with experiences with cultural themes, some of which may be uncomfortable to discuss.

Diversity Dialogue was first introduced to the public in the 2014 first edition of this book, in a chapter titled "Diversity Dialogue: An Innovative Model for Diversity Training" [1]. Since the publication of the first chapter, conversation about diversity issues in the United States has become more heated and the need for every member of society to have cross-cultural communication skills more urgent. The transition of power from President Barack Obama, the first black President, to President Donald Trump, in January 2017, was a time of turmoil and fear for many Americans, particularly those from minority and immigrant communities. Public outrage over the killing of unarmed black men and women, such as Michael Brown in Ferguson, Missouri, and Rekia Boyd in Chicago, led to protest marches and the rise of the Black Lives Matter and Say Her Name movements [2]. The incidence of hate crimes increased during the weeks after the presidential election in November 2016 (although remained lower than their height in 2001) [3] and some hate groups have felt more comfortable expressing racist sentiments publicly, sometimes with violent outcomes such as in Charlottesville, Virginia in August, 2017 [4].

The polarization of society has also been accompanied by an increase in the number of people engaging in political activism. The April 2018 Washington Post/Kaiser Family Foundation Survey on Political Rallygoing and Activism [5], which involved 1850 US adults, indicated that one in five Americans had participated in a rally during 2016/2017 and 20% of those had done so for the first time. There has been growing recognition of the value of white people acknowledging and understanding their own culture as a mechanism to address racial disparities in all areas of American life. Workshops about white privilege are now commonly offered at churches and community centers such as the program "White Privilege, Let's Talk" of the United Church of Christ [6].

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Diversity Dialogue is an initiative that grew out of the work of the Department of Psychiatry Center for Diversity (formerly called Diversity Committee) at MGH. This group was formed in 1997 and has included more than 60 multidisciplinary members of the department, which itself reaches approximately 800 faculty, trainees, and administrative staff. The Center focuses on recruitment, retention, and promotion of faculty and trainees from underrepresented minority groups and on educational offerings for the hospital and wider community.

In 2010, the Center for Diversity was approached to conduct diversity training for a student mental health clinic serving a culturally and economically diverse population of college students and faculty. A series of discussions was held with the requesting clinic, and it was learned that prior diversity trainings using a didactic model focused on clinical competence were not as effective as expected. Drawing from the experiences of peer learning and story sharing in monthly Center meetings, it was decided a new approach was needed and Diversity Dialogue was created.

Since 2010, Center members have conducted Diversity Dialogue with approximately 400 healthcare professionals including mental health clinicians, medical specialty professionals, psychiatry residents, allied health professionals, medical students, hospital administrators, and support staff. The mission is to offer a professionally facilitated opportunity for those working in healthcare settings to share personal stories and experiences with the goal of enhancing the skills needed for effective cross-cultural communication and improved patient care.

Diversity Dialogue is built on the tenet of cultural sensitivity (as opposed to trainings that focus on cultural competence) and emphasizes a philosophy of inclusion, respect, and acceptance of otherness. Our core value is awareness of the unique elements that each individual's cultural and professional background brings to the conversation. When done with groups who are themselves heterogeneous in terms of job titles, Diversity Dialogue allows participants an experience of the reordering of power, an inherent aspect of the patient-doctor relationship. Hospitals are traditionally hierarchical systems in which power differentials have been accepted as part of the institutional culture (doctor/nurse, doctor/patient, attending/trainee, trainee/student, business manager/doctor, etc.). By allowing discussion of often unspoken feelings with a diverse group of coworkers, Diversity Dialogue offers an opportunity for individual members of the team to feel more comfortable acknowledging uncertainty and listening to other perspectives.

Diversity: Equity and Inclusion

Diversity Dialogue, as conceived and implemented by the MGH Department of Psychiatry Center for Diversity, is conducted in healthcare settings. However, the tools used can be applied to other settings. To understand the context of this work, this chapter reviews historical developments of diversity initiatives in the wider United States such as the corporate world and educational institutions as well as healthcare systems.

Diversity Initiatives in the United States

Workplace diversity initiatives in the United States arose out of the cultural and legislative changes of the 1960s. Corporate concern about lawsuits in the wake of the Equal Pay Act of 1963 and the Civil Rights Act of 1964 led to the development of training classes that focused on imparting the "nuts and bolts" of these legislative actions. In their article, *A Retrospective View of Corporate Diversity Training from 1964 to the Present* [7], Anand and Winters discuss the change in focus of diversity trainings in the workplace throughout the last 50 years: compliance in the 1970s, assimilation in the early 1980s, fostering sensitivity between 1980 and the late 1990s, and creating inclusive workplaces from 2000 onward.

At the time of publication of our initial chapter on Diversity Dialogues, research on the effectiveness of diversity trainings in the United States was limited and discouraging. In the intervening years however, new research has been published and is beginning to differentiate specific aspects of diversity training which can make a difference.

In an article titled *A meta-analytical integration of over 40 years of research on diversity training evaluation* [8], Bezrukova et al. note "while many of the diversity training programs fell short in demonstrating effectiveness on some training characteristics, our analysis does reveal that successful diversity training occurs." They start their article by citing the work of many prior authors, pointing out that earlier diversity training research has fallen mainly into two areas:

1. Research looking at diversity trainings using *psychological diversity theory* as a starting point, specifically Alport's contact hypothesis [9] which theorizes that putting people of opposing views together will help them to understand and treat each other better.
2. *Organizational research* which has focused on the context and delivery of diversity training such as where training occurs (school, work, community), how training is reinforced over time, and how motivated learners are for the training. This line of research has led to interest in multimodal trainings [8].

Bezrukova's group analyzed 260 out of 2000 diversity training reports found in the literature. Their analysis found a statistically significant training impact on cognitive learning (becoming aware of issues such as microaggression) which remained stable or increased over time. They theorized that this might be due to cognitive learning being reinforced by news articles, books, and personal experiences which would trigger participants to remember the cognitive information they learned in the training. They found a less robust impact on attitudinal/affective learning which appeared to decay over time. They also concluded "the positive effects of diversity training were greater when training was complemented by other diversity initiatives, targeted to both awareness and skills development, and conducted over a significant period of time." Their review found that the proportion of women in a training group was positively associated with more favorable reactions to diversity training. They found no effect on training outcomes based on whether training was mandatory or voluntary and also found no effect based on whether training was group-specific (for instance, if training was for a group entirely consisting of LGBT individuals) or inclusive (if the training group included a mix of LGBT and heterosexual participants) [8].

Lindsey et al. [10] studied the impact of two specific diversity training exercises on undergraduate students. In one study, looking at the impact of perspective-taking, 118 students were asked to write a few sentences imagining the challenges faced by LGBT or racial minority people. The study showed an increase in pro-diversity attitudes and behavioral intentions toward these groups which persisted 8 months later. In another study, 158 students were asked to set a personal, measurable goal at the end of a diversity training. Results showed an increase in pro-diversity behaviors at 3 months and improved pro-diversity attitudes at 9 months. The authors commented on the role of personality traits and suggested that perspective-taking might make less of an impact on people who are already highly empathic [10]. They also suggested that people who have high social dominance orientation traits tend to be more resistant to diversity trainings and that the presence of a respected authority figure who endorses the training can increase the effectiveness of training for participants with these traits [10].

Bleich, in an article titled *The different types of diversity training that work* [11] says "when it works, diversity trainings make employees feel included and part of a common effort." Bleich cites business reasons for organizations engaging in diversity efforts, including greater retention of employees and reduced cost due to employee turnover. Another factor cited is that companies that value diversity have been shown to have increased sales and profits compared to other companies. Citing a number of prior studies, Bleich offers five factors that contribute to successful diversity training initiatives: *creating common goals; confronting unconscious bias; focusing on inclusion; conducting a training needs assessment; and moving away from prohibitive language (encouraging workers to choose a workplace that values diversity rather than requiring it)*. Bleich concludes "diversity training that presents diversity acceptance as a choice that benefits everyone in the workplace results in positive returns that last longer." Bleich also suggests using tools such as gamification, microlearning and mobile learning to engage workers in diversity learning [11].

In looking at whether diversity trainings are successful in any given organization it is important to consider what measure of success the organization is using. The reasons an individual employer might offer or require diversity training can vary from merely wanting to appear to care about diversity to more deeply held commitments such as increasing diversity in the workplace, better understanding clients' needs or even becoming an agent for change in the community. Ross, in his book *Re-Inventing Diversity* [12], states that "success, unfortunately, is too often defined as fewer diversity complaints raised with human resources and making a half-hearted commitment to increasing diversity in future hires." Kalev, Dobbin, and Kelly [13] analyzed data from 708 private sector workplaces during the time period 1972–2002 and determined that "efforts to moderate managerial bias through diversity training and diversity evaluations are least effective at increasing the share of white women, black women and black men in management" and suggested that the factor that appeared to be most effective was the designation of responsibility for diversity to specific personnel. This enhanced the effectiveness not only of diversity training and networking programs but also increased the overall diversity of managers [13].

Anand and Winters [7] propose that a way to understand diversity trainings is through the concept of triple-loop learning postulated by Robert Hargrove in 1995. Under this theory, single-loop learning teaches skill development, double-loop learning tries to reshape thinking patterns, and triple-loop learning, also known as transformational learning, leads to increased self-awareness and alteration of perspectives [7]. Single-loop learning is the least difficult and most familiar approach. Double loop requires the discipline to measure and follow-up. Triple loop is the most difficult and elusive. It requires the above and both trained and skilled facilitators who are passionate, energetic, and self-aware enough to allow the participants to direct much of the discussion. Anand and Winters [7] theorize that many workplace training programs that have failed to lead to any kind of change fall into the single-loop category.

In addition to the many academic and organizational studies on diversity initiatives, there exists a robust online body of literature on the topic. In an article titled *Must-Read Articles on Diversity in the Workplace: Valuable Insights on the Challenges, Benefits, and Best Practices for Cultivating Diversity* [14], Angela Stringfellow offers a short synopsis and three "take home" points for each of a variety of articles that cross the spectrum from fully supporting workplace diversity initiatives to questioning the effectiveness of these. In this latter category, Stringfellow summarizes an article by Demby [15] who wonders whether the term diversity has become merely a "buzzword" in corporate America and shares this summary of Demby's suggestions for how to change this:

- *"Diversity only can be productive when companies put thought into how to invite and control the resistance against accepted norms"* [14]
- *"Companies need to be prepared to deal with a hefty amount of skepticism when working toward creating more diverse workplaces"* [14]
- *"Companies need to support workers they hire when creating a more diverse workforce because they become representatives of diversity and shoulder much of the resistance and pushback themselves"* [14].

Demby's recommendations [15] are important ones. As representatives of diversity, minority employees often feel neglected. The position of token representative is undesirable to most and they could benefit significantly from administrative and peer support to avoid burnout. Diversity Dialogue is an enterprise that both supports and unites a diverse workforce. Most facilitators of the Diversity Dialogue look forward to the trainings and experiences as both deeply fulfilling and hopeful. It is an opportunity for representatives of minority groups and supportive fellow employees to come together with the support of the administration to work toward a positive goal.

Diversity Initiatives in Healthcare Settings

Early focus on cultural competence in healthcare appeared in the nursing field with recognition that the risk of misunderstanding people from other cultures could have deadly consequences. The field of transcultural nursing was developed by Leininger in the 1950s [16] in response to growing awareness of cultural differences brought forth by a massive increase of immigration. Leininger felt that the learning of specific cultural knowledge, such as holidays, traditions, common cultural missteps, was a necessary component of providing competent patient care. Worried that this approach could result in stereotyping, Ramsden, who worked with Maori women in New Zealand, [17] suggested a focus on developing trust in the partnership between nurse and patient to create “cultural safety” and designed a framework for analysis of the power relationships between caregivers and patients. Simultaneously, in the United States, Campinha-Bacote [18] developed a model of cultural competence “in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client” and suggested that “cultural competence is the process of becoming, not a state of being.” Campinha-Bacote identified five specific elements of this process: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire [18].

Despite their distinct connotations, the terms “cultural competency” and “cultural sensitivity” are often used interchangeably. Cultural competency implies a tangible and reachable body of knowledge with a finite outcome while cultural sensitivity suggests ongoing learning with accumulated skills never reaching a finite end. Given the rapidly changing demographics in the United States, and patients’ unique interpretations of their multiple cultures, cultural sensitivity has become the preferred term.

Cultural sensitivity also entails a critical shift in perspectives employed by healthcare professionals. Culturally competent medical care focuses on understanding culture as it refers to patients and their families. Culturally sensitive medical care, however, includes understanding and incorporating the effects of the cultural backgrounds of providers on interactions with, and interpretations of, patients. In mental health in particular, providers are the very diagnostic and therapeutic tools for patients. Hence, awareness of one’s own cultural and personal biases is critical in assessing and treating diverse populations.

There is a growing body of data that suggests that taking the time and energy to consider the patient’s culture and its impact on communication can affect clinical outcomes [19, 20]. A nonjudgmental approach with the provider acknowledging her ignorance of the patient’s culture can provide an opportunity for learning and building trust. The provider can ask the patient to teach her about what is most important to discuss and decide together. Despite its apparent simplicity, this clinical tool is an infrequent occurrence in general clinical practice. Allowing the patient to briefly act as a teacher, and the provider as the student, decreases power differentials and reduces the barriers to communication.

As society becomes more diverse, and as members of minority communities are increasingly becoming healthcare professionals, cross-cultural encounters in which the clinician is the victim of a racial or cultural insult are more frequently being documented and openly discussed. In an article titled *When a family requests a white doctor* [21], Kimberly Reynolds describes an experience she had as a third year pediatric resident when a parent asked her not to touch his child and requested that the child be reassigned to a white doctor. The article explores the tension between the traditional medical ethical principle of patient autonomy versus the history of racial discriminatory practices in medicine in which black physicians were marginalized or excluded. The author notes the difficulty institutions grapple with in situations where patients make specific requests regarding their care. For instance, the request by a female patient, who has been the victim of sexual assault, to be examined by a female provider, is not the same as the request of a patient who refuses to be examined by a physician from another culture due to prejudicial stereotypes.

One of the authors of the current chapter had the following experience as a young attending on the teaching service of a residency program with predominantly foreign medical graduates. A high proportion were Muslim and from Arabic countries.

"As I was sitting in the nurse's station, a young female resident wearing a hijab came to me mildly flushed and on the verge of tears. She was supposed to be out pre-rounding on the patients. I asked her what was wrong. She told me that Mr. Smith refused to speak with her. He loudly called her a terrorist and demanded to speak with an American doctor. She tried to reassure him it was safe to speak with her as his physician. However, Mr. Smith insulted her with multiple racial slurs until she left the room. I rose from my chair filled with indignation and sadness. In particular, this Muslim female resident was one of the gentlest and hardworking physicians I knew. She was the mother of three small boys and always had a kind word or smile on her face. I did not know exactly what was said, but I could tell she was deeply shaken. I bolted to Mr. Smith's room and confronted him. I asked him what the problem was. He told me he would not work with a Muslim doctor who could be a terrorist. I told him in no uncertain terms that each and every resident was a hardworking, competent, and able physician. I let him know he could decline to work with trainees, but insults and humiliation would not be tolerated. He remained indignant but did listen to what I had to say. The resident remained in the room as I completed the whole interview. Looking back, what I said likely had little impact on Mr. Smith at the moment. However, to this day, I believe it had a significant and positive impact on the female resident who experienced numerous incidents of discrimination and mistreatment."

Factors that Impact Cross-Cultural Communication

The meaning of culture is complex and implies the integrated patterns of human behavior that include thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Conversations about race and culture are often highly charged and loaded with conscious, subconscious, and unconscious biases making them difficult to conduct in professional settings where they are often most needed.

Evidence-based practices in mental health studies rely on well-defined sets of behaviors as ultimate outcome criteria. Diversity, however, is fluid. Discussing it tends to bring up hazy feelings and reactions typical to times of confusion. Discomfort that is carefully monitored by leaders and facilitators may be the most meaningful place to start a discussion about diversity because it enables participants to tap into and express deeper thoughts, attitudes, and biases. Although hard to measure, the authors theorize that allowing the emergence of confusion, discomfort, and vulnerability while talking about diversity in a well-contained environment may – in due course – increase one's adaptability to the rapidly changing diversity in our country.

There are a number of factors that can impact cross-cultural communication. Those who wish to undertake the process of conducting diversity dialogues should become familiar with these topics, or should engage experts, to reduce the risk of inadvertently stigmatizing and traumatizing participants who share sensitive personal stories and beliefs that others strongly disagree with. Facilitators should be aware of the history of racism in our country and how this impacts everyday interpersonal interactions. The term racism is not the same as the term prejudice, for instance, but implies an oppressive system of power over others which includes ideological, institutional, interpersonal, and internalized mechanisms (known as the four I's of oppression) [22].

It is also critical that facilitators are aware of the wide spectrum of potential responses to cross-cultural dialogue. Despite the name of the training and the reality that its existence suggests there are issues of discrimination, some participants may simply disagree or not be aware. It is important to support and protect participants who share an unpopular and less common perspective from the majority of the group. An empathetic and protected environment for both the ignorant and the expert alike is the goal.

Segregation

One of the most basic factors impacting cross-cultural dialogue in the United States is segregation. In 1962 Martin Luther King, Jr., said "I am convinced that men hate each other because they fear each other. They fear each other because they don't know each other and they don't know each other because they don't communicate with each other, and they don't communicate with each other because they are separated from each other" [23]. Despite growing diversity within workplace settings, it remains rare for Americans to have personal relationships with people outside of their own cultural group or to live in a diverse neighborhood. The 2017 Fair Housing Alliance report [24] states "in today's America, approximately half of all Black persons and 40% of all Latinos live in neighborhoods without a White presence. The average White person lives in a neighborhood that is nearly 80% White. Persons with disabilities are also often segregated or prevented from living in their community of choice, both because a great deal of housing is inaccessible and because they experience high levels of discrimination" [24].

In her book *Waking Up White* [25], author Debby Irving describes her life experience of growing up in an upper class white community in the 1950s. She shares the process that led her in adulthood to recognize how little she really knew about the challenges black Americans face every day and describes the education she sought to become a racial justice activist.

Communication Styles

In their article *3 Situations where cross cultural communication breaks down* [26], Toegel and Barsoux state "the strength of cross cultural teams is their diversity of experience, perspective and insight. But to capture those riches, colleagues must commit to open communication; they must dare to share." They go on to discuss three areas in which cultural differences in communication often are evident in the workplace:

- *Differences in participation across cultures with people from egalitarian cultures such as the US feeling comfortable voicing their opinions quickly and openly and people from more hierarchical cultures being more hesitant* [26].
- *Differences in comfort with public disagreement with people from some cultures viewing open conflict as a social failure and people from other cultures viewing it as a sign of deepening trust* [26].
- *Differences in comfort with giving or receiving feedback* [26].

Privilege

Cross-cultural communication is impacted by privilege differentials among participants. Privilege refers to the unearned advantages some members of a society have over others. The most striking example of this in the United States is racial privilege, starting in the 1600s when the term "white" began to be associated with legal privileges denied to black slaves from Africa compared to indentured servants who were mainly white Europeans, thus establishing that even the poorest of white people had privilege compared to those whose skin was dark [27, 28]. Other forms of privilege in American society, in no particular order, include being able-bodied, heterosexual, male, wealthy or young.

In 1988, Peggy McIntosh [29] introduced the "invisible knapsack," a list of 46 everyday ways in which she recognized the privilege of her whiteness and said "I have come to see white privilege as an invisible package of unearned assets that I can count on cashing in each day, but about which I was 'meant' to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, assurances, tools, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear, and blank checks." McIntosh encourages us all to make our own list of the ways in which we have privilege to increase our awareness of, and sensitivity to, those who do not.

In cross-cultural situations such as clinical encounters, members of the privileged culture (however that is defined in that moment) are often oblivious to the ways in which their privilege is impacting the situation. For instance, an able-bodied physician might not think about the challenge for a patient in a wheelchair who lives alone when told they must do a bowel prep for a colonoscopy.

In an article titled *When White Women Cry: How White Women's Tears Oppress Women of Color* [30] scholar Mamta Accapadi discusses the particular tensions that can arise when women of various races and ethnicity engage in dialogue about cultural issues. While all women share lack of privilege compared to men in our society, white women have privilege due to their whiteness which might cause them to struggle to understand issues described by other women. Accapadi gives the example of a meeting in which a black woman's comments about institutional lack of support for women of color cause a white woman to feel she is being attacked and to start crying. The crying derails the discussion, causing the black woman to be viewed as having caused a problem rather than her being able to get the support she was seeking. Accapadi offers a model for understanding privilege identities called PIE (Privileged Identity Exploration Model) [30] and says "Perhaps the most effective use of this model is for self evaluation so that we can recognize when we as educators exhibit these defense modes, when our sense of entitlement based on privilege is challenged."

It is important to note that without training there is no reasonable way to expect the privileged to automatically be aware of their biases. This is exactly why privilege exists and is difficult to address. The beneficiaries of the unearned rights and protections do not imagine how they could be perceived or treated in any other way. They are so immersed in it that it is part of every moment. To borrow an analogy, the hardest thing for fish to see is the water [31]. Less kindly, the privileged perceive the others as blades of grass beneath their feet. They do not wish them harm, but have been walking on them so long, how could that be a problem?

Intersectionality

Closely aligned with the concept of privilege is the concept of *intersectionality*, a term first used by Kimberlee Crenshaw [32] writing from the perspective of black feminism. This concept describes the added burden of oppression experienced by many in our society who have more than one factor that causes them to be marginalized through processes such as ageism, sexism, racism, classism, anti-LGBTQ prejudice, etc. Crenshaw's original description focused on the experience of black women who suffer oppression, both by being women and by being black, whose experiences cannot be evaluated using the framework of white women and oppression due to the inherent difference in privilege of white and black women when facing what might seem on the surface like similar problems [32].

White Fragility

Among the topics those engaged in facilitating cross-cultural discussions should be familiar with is the work of Robin DiAngelo who describes the tension white people can feel in cross racial conversations in her book *White Fragility, Why It's So Hard for White People to Talk About Racism*

[33]. DiAngelo offers the perspective that discussions about race can trigger an internal good/bad binary analysis by white people which makes active discussion of white culture complex. Understanding that racism is bad, individuals might analyze themselves as being "good" because they are not committing conscious acts of racism and will conclude they are different from "bad" or actively racist white people. For some people, once this analysis has occurred, any information that contradicts the analysis, such as discussion of unconscious racial biases, can cause physical and emotional distress which limits further discussion and learning. For those who are open to what DiAngelo says, however, former feelings of discomfort can give way to a deeper understanding of one's own internal processes and a desire to listen and learn in a new way.

Racial Identity Development

Another important topic is racial identity development theory, such as the five step model of minority racial identity development by Cross [34], and the six step model of white racial identity development by Helms [35] (Tables 1.1 and 1.2). While space does not allow for a full discussion here, racial identity theory proposes that at some point in the lifespan, individuals become aware of their cultural identity. For minority individuals, this awareness often occurs during the teen and young adult years with the realization that the individual is being treated differently because of racial/ethnic identity, sexual/gender identity, etc. This awareness is often followed by a period of time in which minority individuals actively reject contact with the majority culture and focus exclusively on relationships with people they see as being like themselves [34]. For those in the majority culture (white, heterosexual, able-bodied, etc.), awareness of cultural identity and social disparities often occurs much later. For majority individuals this awareness can be followed either by a desire to learn about and associate with people of other cultures or alternatively by a retreat back to seeing the majority culture as "normal" and rejection of further cultural education [35]. In both models, some individuals will emerge from these earlier stages to a state of self-awareness that includes openness to authentic relationships with people of other cultures and activism.

Table 1.1 Cross' five step black identity development model [34]

Step	Description
Pre-encounter	Individual views majority culture as normative
Encounter	Adverse experiences cause individual to realize they are seen as "other" by majority culture
Immersion/emersion	Individual focuses on their own culture, learning more about it and reducing or eliminating contact with people of the majority culture
Internalization	Individual feels secure with own identity and feels able to have relationships with people of majority culture
Commitment	Individual begins to actively work in larger institutional areas such as politics to address issues of inequity and racism directed at their cultural group

Table 1.2 Helms' six step white identity development model [35]

Step	Description
Contact	White individual has no/limited contact with individuals of minority culture and no/limited awareness of racism
Disintegration	Awareness of racism begins to develop
Reintegration	Retreat to a more conscious embrace of white culture as superior
Pseudo-independence	Individual begins to intellectually explore concept of racism in society
Immersion/emersion	Willingness to confront one's own personal biases and how one is personally benefitting from racism
Autonomy	Valuing diversity, actively moving toward a non-racist identity

In her article *Talking about race, learning about racism: The application of racial identity theory in the classroom* [36], Beverly Tatum describes her experiences teaching psychology students about racism and how her knowledge of racial identity theory has helped her to understand moments of impasse or conflict in the classroom discussions. This article offers important insights for those engaged in facilitating cross-cultural dialogue.

Assumption and Bias

An *assumption* is something that we accept as true without proof, which our experience has not given us reason to doubt. Assumptions may be challenged when we move from our family or cultural structures into the wider world such as joining the military, going to college or entering the workplace. A student who has been raised in a tight religious community might be surprised, for instance, when first meeting others who do not believe in God. Likewise, a clinician who has had little contact with Asian people might mistakenly assume that all Asian people speak Chinese and ask a Chinese colleague to act as an interpreter for a Korean patient.

While assumptions can arise from lack of experience, they can also be due to lack of knowledge. Many in our society, for instance, retain the belief that race is due to biological or genetic differences between people. Many are unfamiliar with results of the Human Genome Study [37] which showed that genetic differences within groups of people are more significant than genetic differences between groups of people. These and other developments now support the conclusion that race is a social construct rather than due to a biological difference [27, 37].

Bias is commonly defined as a prejudice or predisposition in favor of, or against, one person or group as compared to another, and can be conscious or unconscious [38]. Like assumptions, biases can create blind spots that might cause a clinician to miss valuable aspects of the clinical encounter or to act in ways that patients might see as unwelcoming. An example of bias in healthcare settings might be a heterosexual clinician who routinely fails to ask open-ended questions about sexual practices or a clinician whose feminist attitudes cause her to neglect to ask male primary care patients whether they are feeling threatened in their home setting.

Both assumptions and bias can cause clinicians to feel they intuitively know things about their patients without asking them. This can be especially true when working with patients from one's own cultural group such as a white clinician in the United States assuming that a white patient is literate or has enough financial stability to afford healthy food. In the introduction to the book *Hillbilly Elegy* [39], author J.D. Vance writes "I may be white, but I do not identify with the WASPs of the Northeast. Instead, I identify with the millions of working-class white Americans of Scots-Irish descent who have no college degree. To these folks, poverty is the family tradition—their ancestors were day laborers in the Southern slave economy, sharecroppers after that, coal miners after that, and machinists and millworkers during more recent times. Americans call them hillbillies, rednecks, or white trash. I call them neighbors, friends, and family." Vance also says "that is the real story of my life, and that is why I wrote this book. I want people to know what it feels like to nearly give up on yourself and why you might do it. I want people to understand what happens in the lives of the poor and the psychological impact that spiritual and material poverty has on their children" [39].

Microaggressions

Microaggression is a term coined by Chester Pierce in 1970 to describe the continuing "stain of racism" experienced by African-Americans in our country [40]. Microaggressions, rooted in conscious, subconscious or unconscious biases, were defined by Pierce as "subtle, stunning, often automatic, and nonverbal exchanges which are put-downs." Dr. Pierce suggested that,

> *In and of itself a microaggression may seem harmless, but the cumulative burden of a lifetime of microaggressions can theoretically contribute to diminished mortality, augmented morbidity, and flattened confidence.* [40]

Pierce pointed out that because microaggressions may be expressed consciously, subconsciously or unconsciously, people subjected to them are further hurt by investing expended energies to decipher the perpetrator's intent. In a 2016 essay titled *The Weight* [41], author Rachel Kaadzi Ghansah describes this expended energy when writing about a journalism internship during which an editor told her she was the first black intern to ever work at a 150-year-old magazine. "So when I was the only intern asked by the deputy editor to do physical labor and reorganize all of the old copies of the magazine in the freezing, dusty storeroom, I fretted in private. Was I asked because of my race or because that was merely one of my duties as the intern-at-large. There was no way to tell" [41].

Derald Wing Sue expanded on Pierce's original work and classified microaggressions into three categories [42, 43]:

- *Microassaults* – conscious racist acts such as racist graffiti.
- *Microinsults* – derogatory comments related to a person's race or ethnicity.
- *Microinvalidations* – comments that negate the reality of a person's feelings or experiences.

While Pierce's concept of microaggressions was originally coined to refer to behaviors toward African-Americans by White people [40], the concept is applicable to any minority group such as women in male dominated environments or people with disabilities. Rowe [44, 45], in her role as an ombudsperson at MIT, used the term microinequities to refer to behaviors toward any non-majority individual such as women or minority individuals working in academic institutions or men working in jobs traditionally held by women (such as male secretaries and childcare workers). Rowe also introduced the term microaffirmations as the reverse phenomenon of microaggressions. She defined these as subtle or small acknowledgements of a person's value and accomplishments taking the form of public recognition and commendations [45]. The concept of microaffirmations is an important one for those conducting any kind of workplace meetings in which there is a diverse group of workers. A leader who recognizes that some individuals feel more confident speaking than others, and thus might seem more competent just because they are more vocal, can use microaffirmations to acknowledge and center the contributions of more timid individuals.

In her video *Deconstructing White Privilege, Vital Conversations on Racism* [46], Robin DiAngelo gives a powerful example of the impact of microaggressive behaviors. She describes that during diversity sessions she asks people of color about their interaction with white people with the question "what would your daily life be like if you could simply give us feedback… and have us receive that with grace, reflect, and seek to do something different." She states that on one occasion a man (of color) in the audience answered, "it would be revolutionary."

Parekh et al. [47] provide strategies for overcoming microaggressions in the workplace. The authors suggest that a first step involves recognition and identification of microaggressive behaviors. They argue that it is much easier to identify oneself as a victim of microaggressions perpetrated by others than to recognize oneself as the perpetrator of such behaviors toward others. A greater chance for change however, in the authors' opinion, comes from detection of and reflections upon an individual's own microaggressive behaviors. Once awareness develops, the next steps involve modification of one's own behaviors with the hope of understanding the scope of their impact and moving toward eliminating them [47].

It is essential for individuals to accept their role and contribution in perpetuating microaggressive communications in dyadic or group settings and to courageously engage in a dialogue that shares observations, reflections, and constructive criticism of these relational patterns. Diversity Dialogue sets the stage for conscious awareness of inner biases and welcomes this level of discussion and introspection. It further aims to carefully regulate the pain, discomfort, and vulnerability that are provoked by the uncovering of such microaggressive biases. These aspects of Diversity Dialogue make it a powerful and fertile agent of change.

The Concept of the "Other"

Human beings share the same physiological needs and mortality. On many levels, though, in our very essence, we each hold on to a distinct outlook on the world that is shaped by myriad factors, including but not limited to the groups we belong to. A patient-centered approach that includes emphatic listening to patients, respecting their unique worldview, may equilibrate power differentials. To do so, however, we need to divert away from perceiving people different from us as "others."

The concept of the "other" often serves as a vehicle supporting a skewed definition of "normal." Differences between groups of people are dichotomized to establish power differentials so that members of a dominating group identify themselves as the antithesis of the "other," the subordinated group.

Edward Said, a Palestinian-American literary theoretician, who lived from 1935 to 2003, explored the concept of the "other" in his writings [48]. Said was interested in how people in the Western world viewed people from other cultures and how they depicted them in literature. In his early career he earned attention for his literary analyses of authors such as Joseph Conrad (Heart of Darkness) and Rudyard Kipling (The Ballad of East and West). In his book *Orientalism* [48], Said critically analyzed the Western study of Eastern cultures and illuminated the numerous ways that the "Orient" has been defined by authors of the West as its contrasting image, idea, and personality: the West in general portrayed as more powerful and "masculine" and the East as more mysterious and "feminine." Said asserted that a necessary prerequisite to generating massive and imaginative projections of this kind was the establishment of a power relationship between the West and the East that resulted in the dominating force feeling empowered to speak of, and for, the "Orient." He emphasized that the "Orient" is an idea that has a history, a tradition of thoughts, imagery, and vocabulary that have given it reality and presence in and for the West irrespective of the accuracy with which it reflects true characteristics of the East [48].

Social processes use dichotomous distinctions between groups of people to enhance power differentials and to allow for ongoing use of the "inferior other" for the purpose of identifying and idealizing the dominant "superior" group. Said posed the critical question: "How can one study other cultures and peoples from a libertarian, or a non-repressive and non-manipulative, perspective?" Dominating groups have to acknowledge their definitions of the "other," the minority groups, as their own projections and to allow for and listen to the "other" speaking openly of and for themselves [48].

One potential consequence of being viewed as "other" is that an individual will internalize the projection of the majority culture. An example of this is offered in the book *Body of Truth* [49]. Author Harriet Brown quotes a 60-year-old university professor talking about how fat shaming impacted her. "I first found out I was a fat person in kindergarten when people I didn't know before told me I was a fat person…The tragedy for me is that I judge other large people the way people have judged me. I find myself looking at a large person and assuming they don't care enough to look right. And that they probably are lazy. And that they're probably stupid. And I know that that's how people have judged me in the past. It's incredible to me that I do that. And I wish I didn't." [49]

Why Dialogue?

In an article titled *What is the Dialogical Method of Teaching* [50], Shor and Freire discuss a method of teaching, initially developed by Freire, which "rejects narrative lecturing where teacher's talk silences and alienates students." Freire's model, called Liberatory Education, developed in Brazil as an adult literacy movement for oppressed people in the 1950s. Freire calls traditional didactic-learning the "banking model" and describes it as a process in which the student is an empty container to be filled with knowledge by the teacher who holds all the knowledge. He argues instead for a model of education in which both the teacher and the student are holders of knowledge to encourage students to speak from personal experience and consequently voice what they, the students, know. Freire says that "dialogue is a challenge to existing domination… the object to be known is not an exclusive possession of one of the subjects doing the knowing…the object to be known is put on the table between the two subjects of knowing" [50]. In Freire's model, the dialogue is not a spontaneous conversation but it takes place inside a program and context where both the teacher and students are constantly learning and relearning. "If the dialogical teacher announces that he or she relearns the material in the class, then the learning process itself challenges the unchanging position of the teacher. That is, liberatory learning is a social activity which by itself remakes authority" [50].

Others have also written about the importance of dialogue. Yankelovich [51] suggests that while "ordinary conversation presupposes shared frameworks...dialogue makes just the opposite assumption: it assumes that participants have different frameworks. The purpose of dialogue is to create communication across the border that separates them." Gerzon [52] says that "the power of debate is that two polarized voices are free to speak. But the power of dialogue is that these voices can actually be heard." Gerzon also proposes that "dialogue can only happen to the degree that the participants are willing to engage in the process. Only then can mistrust evolve into trust." He emphasizes the power of re-evaluating our assumptions and allowing them to be challenged, all of which are crucial factors in achieving a successful dialogue [52].

Recognition and appreciation of the various forms language can take enhances the power of a dialogue. In Western culture, dichotomy and binary systems are inherent structures of language and logic. Language, while clearly defining polarities of any given human quality, may fail to represent gradations or "in-between" variations of the same quality. Some languages may propose a host of nouns or adjectives to note or describe a given phenomenon while other languages may totally lack or have only a few terms for the same phenomenon. Concepts and expressions with inherent "either/or" structures typically convey underlying judgmental and value-loaded notions such as right/wrong or good/bad. Eliciting alternate perspectives may loosen rigid "either/or" structures in favor of more nuanced discussions.

Volosinov [53] claims that a word is a two-sided act, a bridge built between people, and suggests that expression organizes experience by providing its form and specificity of direction. Volosinov suggests that a realized expression – as opposed to a suppressed or inhibited expression – is operating on experience in reverse direction, beginning to tie inner life together by giving it more definite and lasting structure. It is therefore "a matter of not so much of expression accommodating itself to our inner world but rather of our inner world accommodating itself to the potentialities of our expression, its possible routes and directions" [53].

Similarly, White and Epston [54] propose that what people know of life they know through "lived experience" and that in order to make sense of our lives and to express ourselves, experience must be "storied." Due to the richness of lived experience, only a fraction can be "storied" and expressed at any given time; "those aspects of lived experience that fall outside of the dominant story provide a rich and fertile source for the generation, or re-generation, of alternative stories." Thus, in White and Epston's view, the text analogy proposes that people's life stories are situated in texts within texts and that every telling or retelling of a story, through its performance, is a new telling that encapsulates and expands upon the previous telling [54].

Diversity Dialogue: Structure and Course

As already mentioned, Diversity Dialogue is a 3-hour training workshop conducted by a team of multidisciplinary members of the Center for Diversity including psychiatrists, psychologists, social workers, nurses, and administrators with expertise in mental health and cross-cultural issues (Table 1.3). Diversity Dialogue has four stages along with distinct Pre- and Post-Dialogue activities.

Table 1.3 Multidimensional comparisons between two diversity education models

Diversity dialogue	Traditional diversity training
Focus on cultural sensitivity/humility; implies ongoing learning with accumulated skills never reaching a final end	Focus on cultural competence; implies a finite outcome with a tangible and reachable skill set
Uses double-loop learning that reshapes thinking patterns and triple-loop or transformational learning that increases self-awareness and alteration of perspectives [7]	Uses single-loop learning that focuses on skill development [7]
Focuses on raising unspoken societal issues that are pertinent to the targeted audience in a professionally facilitated holding environment	Focuses on more specific objectives: compliance in the 1960s and 1970s, assimilation in the early 1980s, fostering sensitivity in the 1980s and 1990s, and creating a sense of inclusion from 2000 to present time [7]
Trainers are active participants who express their perspectives to gain increased awareness of their own limitations and biases	Trainers are not active participants and their own biases are not examined
Liberatory Model where both the teacher and the student are holders of knowledge and both are continuously learning and relearning so that the object to be known is not an exclusive possession of one but lies in the space between the two [50]	Traditional, didactic, or "banking model" where the teacher is the holder of all knowledge and the student is an empty container to be filled with knowledge [50]
Challenges existing power differentials; offers an opportunity to reduce unspoken tension in power relationships through the social activity of a dialogue [50]	Potentially reinforces existing power differentials
Assumes different frameworks with the purpose of creating communication across the borders that separate people and allowing polarized voices to speak and be heard [51, 52]	Presupposes shared framework with less tolerance to polarization or diverse perspectives [51, 52]

Pre-Dialogue Needs Assessment and Planning

Each Diversity Dialogue is preceded by a Pre-Dialogue Needs Assessment Stage. The Center for Diversity Dialogue team appoints two co-leaders for each workshop and six facilitators. Once a group of 20–25 participants from a requesting group (hereafter called client) is identified, Dialogue leaders meet with appointed leaders of the client group to explore the reasons for the request and the unique needs of the group, along with gauging their expectations for the workshop. A series of three to five Pre-Dialogue meetings are held to ensure that expectations are understood on both sides and that logistical issues are being adequately addressed. Finding a 3- to 4-hour block of time during which all participants can be separated from clinical and administrative duties without interruption, as well as finding adequate space for the workshop, can be daunting and contributes to the Pre-Dialogue phase usually lasting several months.

We recommend conducting Diversity Dialogues in a space that can be set up with a U-shaped table for the early part of the Dialogue (so that all participants can easily see and hear each other) and that also has space for smaller "break out" groups later in the Dialogue.

Having the support of department and hospital leadership is an important aspect of a successful Dialogue. Tangible measures of leadership support have included providing salary/productivity credit for the hours participants spend at the Dialogue and department leadership being present at the start of each Dialogue to tell participants how much they personally value having a diverse workforce and to thank participants for joining the Dialogue.

Facilitator Training

Each Diversity Dialogue includes Pre-Dialogue training for small group facilitators to acquaint them with the issues discussed in this chapter. Facilitators of Diversity Dialogue have later expressed a sense of personal humbleness and fulfillment of long-held wishes to be part of an initiative that moves beyond traditional diversity training structures. One such testimony was offered by one of the authors of this chapter: "Nothing could have prepared me for my journey from participant to repeated facilitator. To be honest, as a person of color who has been dealing with racial and cultural issues since elementary school, I never expected to learn as much as I have. For background, I am Latino with skin a few shades lighter than a Hershey bar. I have been called black as well as all the related slurs. At other times, people thought I was Indian or Arabic. When I told my high school calculus teacher I was accepted to an Ivy league college, he whispered in my ear that it was really helpful to be a minority.

Where are you from? Do you speak English? Are you legal? I am quite familiar with all these questions as recently as last week. Going into my first Diversity Dialogue, I thought I knew a bit about the impact of bias and discrimination on others. The training started with a video that focused on an overweight white female being thought of as not talented, not desirable, and unlikely to succeed. The group went through all the ways this overweight white female was devalued. I was confused and dismayed. With all the potential scenarios involving gender, country of origin, language ability, or presumption of gender roles, how could we possibly even start with something as seemingly benign as the mistreatment of an overweight white woman who notably succeeds and excels at the end of the scenario. I thought surely this was too obvious and basic an example to elicit much discussion.

I could not have been more wrong. The participants were engaged and made many thoughtful comments. This overweight woman's plight spoke to them in a way they could relate to. The somewhat benign nature and less controversial example of discrimination allowed people to share more freely. I did not come to this realization easily. I had to talk it through in detail and share my shock and confusion with a more experienced member of the Center for Diversity. She supported and guided me through my own biases and discrimination against people who had spent little to no time or energy dealing with issues of race or discrimination.

After my first time as a facilitator, I realized that my own expectations of baseline sensitivity and understanding from the participants had hampered my performance. Afterward, I was increasingly able to see and accept participants' starting points. Therefore, I was better able to support and encourage the process. Each Diversity Dialogue helped me move forward and open my mind to the next group's experiences. It has been immensely helpful to see the varied reactions and deeply personal stories from the groups of participants. Their bravery to expose their vulnerabilities and share amaze me each and every time. I am thankful the safe spaces created by the Diversity Dialogue exists and privileged to be a part of it."

Setting the Frame

Each 3-hour Diversity Dialogue starts with several minutes of discussion about creating a safe space for the Dialogue and confirmation that participation is voluntary. Participants agree to goals of:

- Creating a safe space
- Engaging honestly
- Taking risks and exploring their beliefs/biases
- Keeping an open attitude
- Treating the Dialogue as an opportunity for learning
- Focusing on personal experiences
- Showing a willingness to learn and respect differences
- Identifying one to two issues of personal interest

Stages of the Training

Stage I: "Getting to Know Each Other"

In Stage I, which typically lasts for an hour, participants share personal and unique aspects of their heritage or place of upbringing that helped shape them into the person they became. Participants receive an email during the week prior to the Dialogue asking them to come prepared to give a

2-minute introduction of themselves that does not involve their professional activities or accolades with the prompt “tell a story of where you are from – geographically, spiritually, culturally, ethnically, socio-economically, your home culture or any other cultural theme that contributed to making you the person you are today.” Participants are encouraged to bring a small object they feel symbolizes an aspect of their cultural history to accompany this introduction. Common themes are stories about countries of origin, religious traditions, cross-cultural marriages, lost loved ones, or hobbies that have led to a community that has become family. Younger members, such as students and house staff, often share stories about study abroad years when they have felt an awakening of awareness of their own heritage while immersed in the setting of a different culture. At the end of this first hour participants often unite or bond in a different way – around the experience of sharing treasured and at times nostalgic memories. Everyday power differentials – such as manager/employee, male/female, doctor/nurse, and teacher/student – begin to fade into the background as stories and a sense of togetherness are shared by the group.

Stage II: Didactic/Cognitive Learning

In our early Diversity Dialogue workshops, Stage II of the Dialogue consisted of a 1-hour structured didactic scientific or empirical presentation by a seasoned researcher or clinician on a topic carefully chosen by the Dialogue leaders to be pertinent and informative to the particular group of participants. Topics included ways to engage patients from different cultural backgrounds in medical or psychiatric interviews, how patients see their healthcare providers, and a scientific talk about the neuroanatomy of fear and its association with unconscious biases.

Over time, as Diversity Dialogue facilitators received feedback from participants about how much they value the discussion parts of the Dialogue, the didactic portion was shortened to 20–30 minutes on the themes of assumption, bias, and microaggression. A short video depicting a cross-cultural vignette is often included.

Stage III: Building Awareness/Small Group Discussions

In Stage III of Diversity Dialogue participants are divided into small discussion groups, each accompanied by two facilitators. Clinical participants are invited to share a personal story about a clinical encounter they have experienced that they felt was impacted by a cultural difference between themselves and the patient; however, they define culture. Nonclinical staff are asked to share a personal story from their school years or training in which they recognized they or others were making a decision based on an assumption or bias or in which they witnessed or experienced microaggression. A further prompt for the discussion is “did anyone do anything to make the situation better or worse? Are there things you wish you had known then or tools you wish you had?”

Stage IV: Large Group Reflections and Intention

In Stage IV of Diversity Dialogue, participants convene as a large group to share highlights of the themes discussed in their small groups.

At the end of the large group reflection, participants are invited to spend a few moments thinking about a personal intention, or next step, they wish to set for themselves as they leave the Dialogue. Several years after attending a Diversity Dialogue, one clinical director said “We made some programmatic changes to our staff meetings as a result of my going through the Diversity training you ran. These were aimed at ensuring that all present speak up and that their contributions are valued...I changed my awareness/behavior as a leader following your session. I have seen that others have as well.”

Post-Dialogue Evaluation Stage

At the end of Diversity Dialogue, participants are asked to fill out a survey in which they reflect on their experience and point to high and low moments in this workshop (see Appendix). Comments offered in these surveys are carefully studied and incorporated in future Dialogues. Additionally, an evaluation meeting is held immediately after the Dialogue for facilitators and the leadership team of the client group; other participants are also invited to stay. First impressions of the dialogue are gathered and logistical issues such as timing, the location and size of the space are also discussed.

Post-Dialogue surveys routinely indicate high satisfaction among participants, with a majority citing the introduction hour and small group discussions as being the parts of the Dialogue they most value. It is not uncommon to hear participants say they have worked in the same department for years but never before known anything personal about each other. Many participants indicate that learning about the concept of microaggressions has given them a new perspective on their own behaviors and past experiences.

Closing Comments

Americans frequently cite their first amendment right to freedom of speech, particularly when saying something that is hurtful or when speaking without listening. Author Brenda Ueland wrote "Listening is a magnetic and strange thing, a creative force. The friends who listen to us are the ones we move toward. When we are listened to, it creates us, makes us unfold and expand" [55].

Diversity Dialogue, designed and piloted by the Center for Diversity, Department of Psychiatry at Massachusetts General Hospital, offers the opportunity for healthcare professionals to transcend barriers of authority and power, relinquish the concept of the "other" and listen to each other in ways that are new and meaningful. It is built upon the principle of diverting away from dichotomous or either/or thinking processes and allowing polarities and diverse perspectives to reside within a given discussion, provoking feelings of discomfort and eliciting change through sharing stories and opening to new thought patterns. Diversity Dialogue does these using tools that have been associated in the literature with successful diversity efforts. These include Pre-Dialogue meetings to assess client training needs and eliciting leadership support in tangible ways prior to the dialogue. Cognitive learning on topics such as microaggression is included in the structure of the dialogue. At our institution this is reinforced with hospital wide programming on topics related to racism and stigma throughout the year. The structure of the Dialogue allows for participants to do most of the talking, another feature cited in studies that look at successful diversity initiatives. At the end of Diversity Dialogue participants are invited to make a commitment to themselves for a "next step" that will reinforce an aspect of the Dialogue they found meaningful.

In 2014, a stated goal of Diversity Dialogue was "to increase tolerance of and curiosity about diversity and to ultimately assure the best quality of care for all patients" [1]. While this goal remains, in 2018 the polarization of society that has occurred in the last 2 years gives greater urgency to this work and to the ongoing personal commitment of participants. Tolerance and curiosity about diversity are no longer enough. Healthcare professionals must actively embrace learning about these concepts, to understand the varied and unique perspectives of patients from all parts of our society who come to them for care. They must strive to understand their own unique cultural identity and how this impacts their interaction with patients. This is particularly true for white clinicians who may not yet feel comfortable with discussion of the history of white culture and racism in our society. Or, those who may wrongly feel they need to project a color-blind attitude which ignores the day-to-day reality of oppression in patients' lives and the impact this has on health.

Lastly, in order to create diverse workplaces where the racial and ethnic demographics of clinicians will begin to approximate those of patients, efforts to broaden knowledge about topics related to diversity must be coupled with efforts that acknowledge how biases and oppression impact equity and inclusion in the workplace and in the delivery of healthcare. Diversity Dialogue offers a framework in which participants can begin to communicate about these complex and often uncomfortable topics, despite differences, and to build the relationships needed for working together over the long term to make meaningful change.

Appendix: Post-Dialogue Evaluation Survey

Department ________ Staff ________ Admin ________

Gender: female ________ male ________ trans ________ other ____

Q1 Diversity training is relevant to my current practice

strongly disagree	somewhat disagree	neither disagree or agree	somewhat agree	strongly agree
1	2	3	4	5

Q2 Diversity training is relevant to my professional relationships

strongly disagree	somewhat disagree	neither disagree or agree	somewhat agree	strongly agree
1	2	3	4	5

Q3 I feel confident dealing with patients \ people of a background different than myself

strongly disagree	somewhat disagree	neither disagree or agree	somewhat agree	strongly agree
1	2	3	4	5

Q4 Compared to other trainings / lectures, diversity / cultural sensitivity is as important

strongly disagree	somewhat disagree	neither disagree or agree	somewhat agree	strongly agree
1	2	3	4	5

Q5 I am a culturally confident clinician\person

strongly disagree	somewhat disagree	neither disagree or agree	somewhat agree	strongly agree
1	2	3	4	5

Q6 My professional training has adequately trained me to participate in the care of patients of diverse backgrounds

strongly disagree	somewhat disagree	neither disagree or agree	somewhat agree	strongly agree
1	2	3	4	5

Q7 My department\supervisors\ colleagues encourage cultural discussions

strongly disagree	somewhat disagree	neither disagree or agree	somewhat agree	strongly agree
1	2	3	4	5

Q8 Have you had diversity / cross cultural trainings in the past?

No Not sure Yes

Q9 Why & how is understanding diversity important?

Q10 What did you expect from today's dialogue and were your expectations met?

Q11 Was this diversity dialogue useful and which part of it was most helpful? What stands out for you that you heard\learned today?

Q12 How could we make this dialogue more relevant and helpful to your experience in your Department?

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2

The Engagement Interview Protocol (EIP): Improving the Acceptance of Mental Health Treatment Among Culturally Diverse Populations

Nhi-Ha T. Trinh, Trina Chang, and Albert Yeung

Introduction

Many patients from diverse cultural backgrounds are unfamiliar with Western biomedical psychiatric terminology and have high levels of stigma toward psychiatric illnesses. To enhance communication between clinicians and patients and engage patients in psychiatric treatment, we designed the Engagement Interview Protocol (EIP) to incorporate cultural components into a standard psychiatric evaluation. The EIP elicits patients' narratives and explores patients' illness beliefs, which are integrated with patients' information on medical and psychiatric history, psychosocial background, and mental status examination so that clinicians can negotiate treatment options in a culturally sensitive manner.

The EIP was developed specifically for mental health clinicians to use during the diagnostic clinical interview. However, the conceptual framework of the EIP endeavors to approach diversity and understanding of mental health in a creative way, outside the usual "medical model." This chapter reviews the growing diversity of the US population, the importance of understanding cross-culturally mental health and illness beliefs, and the development and medical application of the EIP. The concepts behind the EIP itself have a multidisciplinary origin and can be adapted to clinical, educational, and research settings to promote an increased appreciation for diversity.

The increasing plurality of the US population: The United States is becoming increasingly diverse as the growth rate of minority groups is outpacing that of the White population. Between 2000 and 2010, the Hispanic population in the United States grew by 43%, increasing from 35.3 to 50.5 million, composing 16% of the total population; in 2010, nearly one in six US residents were Hispanic [1, 2]. The Asian population increased from about 4% in 2000 to about 5% in 2010, and the Black population rose from 12% to 13% of the total population. The American Indian and Alaska Native population maintained its proportion of the total population (0.9%) while growing from 2.5 to 2.9 million. In contrast, while the White population increased from

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211.5 to 223.6 million in the same period, its share of the total population fell from 75% in 2000 to 72% in 2010.

This increase in the proportion of minority populations in the United States is expected to continue, leading to a dramatic change in the demographic profile of the United States [3, 4]. By 2050, the nation's population will rise to 438 million, from 296 million in 2005, and fully 82% of the growth during this period will be due to immigrants arriving from 2005 to 2050 and their descendants; nearly one in five Americans (19%) will be foreign-born in 2050, well above the 2005 level of 12% [5]. According to US Census estimates, by 2044 no race or ethnic group will comprise greater than 50% of the nation's population, meaning the United States will soon become a "majority-minority" country [6].

Minority Mental Health in the United States

Despite the trend of growing ethnic diversity, disparities in mental illness treatment continue to be a significant public health challenge, as minority patients with mental health illnesses are less likely to receive treatment than White patients [7]. For minority patients who do receive mental health treatment, both the quality of services and patient satisfaction are lower than those of the White population. The disparities in mental illness treatment among ethnic groups have been attributed to a number of factors. One of the most important causes is lower health literacy and divergent understandings of mental illnesses among minority populations. In addition, the lack of available resources among minority patients, insufficient culturally compatible services, and higher stigma of mental illness among minority populations play important roles [8]. Individuals from nonmajority cultural groups often report less satisfaction with healthcare treatment, less shared decision-making with their providers, and less overall trust in their providers. These disparities increase with racial, ethnic, and linguistic discordance between doctor-patient dyads and appear to be further increased in those who have experienced discrimination [9]. In our earlier study of Chinese immigrants in Boston's Chinatown, the prevalence of major depressive disorder (MDD) was 19.6% among underserved Chinese immigrants in an urban primary care setting, and most of them (96.5%) were untreated [10]. In this chapter, we will utilize our experience of working with Asian immigrants to demonstrate how to develop culturally appropriate interviews as a way to address this public health challenge and to bridge these gaps.

Culture and Illness Beliefs

Medical anthropology distinguishes between disease and illness as two distinct aspects of sickness. Disease refers to a malfunctioning of biological and/or psychological processes, while illness refers to the psychosocial experience or meaning of perceived disease. Illness is created by personal, social, and cultural reactions to disease [10]. People from different cultures have distinct illness beliefs about the nature of the illness, its appropriate treatment, and the kind of relationships within which treatment can take place [11]. For example, Marsella [12] suggests that the experience and expression of depressive disorders may vary according to the degree of Westernization. In European and North American cultures, depression is a well-accepted psychiatric syndrome characterized by specific affective, cognitive behavioral, and somatic symptoms. By contrast, in Nigerian, Chinese, Canadian Eskimo, Japanese, and Southeast Asian cultures, equivalent concepts of depressive disorders are not found [13]. The resulting discrepancy in illness conception between patients and physicians may explain the lack of motivation of many minority patients to receive treatment for depression.

Cross-Cultural Studies of Illness Beliefs

Several studies have investigated illness beliefs about depression in specific cultural groups. Our team used the Explanatory Model Interview

Catalogue (EMIC) [14], a standardized instrument for studying illness beliefs, to investigate depressed Asian Americans with a low degree of acculturation and found that many of them were unaware of, or were unfamiliar with, the concept of major depression [15]. This result may explain why many Asian Americans focus on physical symptoms and underreport their depressive symptoms. It may also explain the clinical challenge of conveying the diagnosis of depression to Asian immigrants, as many of them are unfamiliar with the illness or might hold strong stigma against being diagnosed with any mental illness [16].

In another study on the illness beliefs of mental illnesses among different ethnic groups [17], participants were asked, "What do you think causes depression?" Compared to non-Latino Whites, African Americans tended to view mental illness as caused by stress and loss—e.g., the loss of family friends, stress over money, and stress or worry in general. Asian Americans were more likely to believe that family issues, medical illness, and cultural differences caused mental illness. Latinos tended to attribute mental illness to the loss of family and friends, family issues, and moving to a different place. Participants were also asked, "If you had a mental health problem, what do you think would help you get better?" Compared with non-Latino whites, a greater proportion of African Americans said that they would seek spiritual advice to help them with a mental health problem, while Latinos were more likely to endorse a preference for medications; Asian Americans showed no significant differences in their preferred treatment modalities as compared to non-Latino Whites.

These studies demonstrate the impact of culture on illness beliefs, including the attribution of causes of illness and treatment preference. To effectively treat patients from diverse cultural backgrounds, clinicians need to understand, appreciate, and effectively negotiate the different viewpoints of the patients they are treating to develop a shared understanding of illness and disease. This negotiation can be particularly challenging when clinicians come from different cultural backgrounds than their patients. Even when clinicians and patients share similar backgrounds, it is not uncommon that they diverge in the conceptual frameworks they use to understand a particular illness [8]. Training that is focused on fostering an attitude of cultural respect and humility is sorely needed to equip psychiatrists for this challenge [18].

"Cultural humility" or the "ability to maintain an interpersonal stance that is open in relation to aspects of cultural identity that are most important to the patient" has been proposed as a key attitude that predicts success within cross-cultural clinical encounters [19]. Of note, this movement has gained favor in the field of healthcare over the previously widely used term "cultural competence," which has been more recently criticized for implying that there is a finite and static goal to be attained rather than an overall approach or attitude that considers the dynamic and multidimensional nature of culture.

Clinicians must be prepared to address a wide range of potential experiences that impact their patients. The shift from knowledge to skills as critical; continuing education, by necessity, includes not only the acquisition of knowledge, more importantly the development of skills as well as attitudes, which may ultimately prove to be more useful. The culturally humble clinician expresses respect and a lack of superiority regarding the patient's culture and does not assume competence in terms of working with a patient simply based on prior experience with other patients from similar backgrounds. To address these challenges, our team developed the "Engagement Interview Protocol" to incorporate cultural components into the standard psychiatric interview [4] (see "Engagement Interview Protocol" below).

The Engagement Interview Protocol

The EIP is a semistructured instrument that integrates patients' illness beliefs into psychiatric assessment and evaluation to improve the acceptance of psychiatric treatment among culturally diverse populations. By using the information obtained from the EIP, clinicians may develop co-constructed illness narratives with patients and reframe the Western concept of depression into more culturally resonant forms [20].

Development of the EIP

The EIP is based on the format of a standard psychiatric diagnostic interview, which typically consists of the following sections: History of Present Illness, Past Medical History, Psychosocial History, Mental Status Examination, and Psychiatric Diagnoses. To the standard diagnostic interview patients' narratives of their illness, the EIP adds eight anthropological questions [11] to explore patients' illness beliefs in the "History of Present Illness" section and introduces two new sections, one on "Culturally Sensitive Disclosure of Diagnosis" and another one on "Customized Approach to Treatment Negotiation."

Incorporating Culture in Psychiatric Assessment

The keys to providing culturally sensitive healthcare are developing the ability to understand the meanings of illness from the patient's perspective within the context of his/her cultural background, as well as effectively communicating the basis of the medical treatment and its potential benefits using a framework and language that the patient can understand [20]. To bridge different worldviews of people from different cultures in clinical encounters, clinicians may apply the anthropological approach: collecting and analyzing both the "insider's" or "native's" interpretation or "reasons" for his or her customs/beliefs, as well as examining their (the external researcher's) interpretations of the same customs/beliefs [21]. This approach contrasts with the approach that is being practiced or taught to clinicians, which emphasizes improving the reliability of psychiatric diagnosis: Clinicians nowadays are typically trained to collect data so that patients' conditions can be classified as DSM-5 disorders based on the presence or absence of certain symptoms [22]; the patient's perspective can be overlooked or considered as "noise" in the processing of clinical data.

The understanding of the patient's perspective becomes much more important when a clinician sees patients from a culture that is significantly different from his or her own. In such encounters, the clinician is again like an anthropologist who tries to describe the lives and world of the patient of a foreign culture; here the clinician focuses on learning about the patient's illness beliefs. To understand patients' illness beliefs, Kleinman proposed listening closely to patients' narratives and using eight anthropological questions to summarize the key elements of patients' illness beliefs to bridge the clinicians' and patients' perspectives on the illness [11]. These eight questions include: (1) What do you call your problem? What names does it have? (2) What do you think has caused your problem? (3) Why do you think it started when it did? (4) What does your sickness do to you? How does it work? (5) How severe is it? Will it have a short or long course? (6) What do you fear most about your sickness? (7) What are the chief problems the sickness has caused for you? (8) What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

Most clinicians find these questions very helpful to understand the patients' perspectives regarding their illness. However, many find it hard to memorize these eight questions in their clinical work. To help clinicians remember these eight questions, we created the acronym "**PERCEPTS**":

- What is the **P**roblem which bothers you?
- What is its **E**tiology?
- What do you think is a good **R**emedy or treatment?
- What do you **C**all the problem?
- What are its **E**ffects on you?
- How much are you **P**erturbed (or do you fear) by the problem?
- What do you think **T**riggered the problem?
- How **S**evere is the problem?

In order to describe the influence of culture on patients, on their illness beliefs, and on clinical encounters, the DSM-5 [22] presents the Outline for Cultural Formulation (OCF) model and the Cultural Formulation Interview (CFI), which operationalizes the OCF. The current CFI is a standardized, manualized interview based on 16 stem questions and probes [22]. The DSM-5 OCF and CFI uses a semistructured evaluation format for the individualized assessment of cultural factors, including the patient's identity, illness experience, and context, as well as of the clinician-patient relationship. In this model, every patient's cultural background is described in a brief text that includes (a) the patient's cultural identity, (b) cultural explanations of the individual's illness, (c) cultural factors related to psychosocial environment and functioning, (d) cultural elements of the relationship between the patient and the clinician, and (e) an overall assessment of diagnosis and care [23, 24]. The DSM-5 OCF and CFI are a detailed assessment that provides a comprehensive description of the impact of culture on the patient, his/her illness beliefs, and the dynamics between the patient and the clinician. However, as it requires extensive information gathering, limiting its value as a practical tool for daily clinical work.

To address this issue, we developed the EIP, which can be completed within the 1-hour psychiatric interview, the time allotted by most clinicians and health insurance plans for an initial psychiatric diagnostic assessment. EIP uses a streamlined approach focusing on bridging the patient's and the clinician's understanding of the illness to overcome cultural barriers, with the goal of engaging patients in psychiatric treatment. The EIP is based on the format of the standard psychiatric assessment but adds to it cultural components based on our clinical experience serving immigrant populations from diverse cultural backgrounds: the patient's narratives of his/her illness experience, Kleinman's anthropological questions on the patient's illness beliefs, culturally sensitive communication of psychiatric diagnoses, and negotiation of disposition options. The EIP comprises six sections: (1) History of present illness, including the patient's illness beliefs, (2) Psychosocial history, (3) Mental status examination, (4) DSM-5 diagnoses, (5) Culturally sensitive disclosure of diagnosis, and (6) Customized treatment negotiation. Equipped with this information and understanding, clinicians are better able to use mutually understood terminology and conceptual frameworks when they talk with patients about their experiences and treatment options.

The Elements of the Engagement Interview Protocol

History of Present Illness with Illness Narratives and Illness Beliefs

The "History of Present Illness" section records key clinical information about the onset of illness, precipitants, presenting symptoms, the course of illness, factors that exacerbate or alleviate the symptoms, impairment of social and/or occupational functioning, and responses to treatment. Both the patients' illness narratives and answers to the illness belief questions are explored in this section of the EIP.

Patients' Illness Narratives

To understand patients' own illness beliefs, it is important to offer patients the opportunity to tell stories about their illness using their own language and conceptualizations. The narratives frequently reflect how patients' culture and social environment influence the formation, shaping, and presentation of their symptoms. Such stories are described by anthropologists as "mini clinical ethnographies," which can be elicited by clinicians asking open-ended questions about the patients' concerns and distresses and allowing sufficient time, attention, and interest for patients to describe their understanding of their illness [14, 25]. By empathically listening to the patients' illness narratives, the clinician can learn the patients' perspective and enter into their experiential world.

Patients' Explanatory Models

Understanding the "cultural explanation of the individual's illness" is essential for achieving an intuitive and empathic understanding of the cultural meanings of symptoms to patients, for shaping how illness will be disclosed to the patients, and for negotiating treatment approaches.

To elicit the patient's cultural explanation of his/her illness, the EIP has included the "PERCEPTS" questions based on Kleinman's eight anthropological questions [11]. This data enables clinicians to co-construct interpretations of the illness with their patients, which is usually done by bridging DSM diagnostic categories with the individual's concepts. Such a process is used below, both for communicating about patients' illness and for discussing treatment options in a culturally sensitive way.

Psychosocial History

This part of the psychiatric interview elicits information on the patient's personality, cultural affiliation, self-identity, childhood experience, education, job history, aspirations, and major life goals. It corresponds to two core elements of the DSM-5 Cultural Formulation model: the "cultural identity of the individual" and the "psychosocial stressors and cultural features of vulnerability and resilience."

To understand the psychosocial history of the patient, the EIP uses direct questioning to elicit information on patients' developmental, immigration, and work history, current social environment, and perceived stressors. These items include (1) country of origin, childhood developmental experience, and school and social experiences; (2) level of education and the schools attended; (3) immigration history (when applicable), including the reason for immigrating to the host country and how it took place, the duration of stay, current immigration status, cultural reference group, language abilities, degree of involvement with both the culture of origin and the host culture, and the extent to which the goals of immigration have been achieved; (4) marital status, relationship with spouse, and current marital issues if present; (5) spiritual/religious beliefs and the role of religion in the patient's life; (6) family members, their locations, their socioeconomic status and occupation, and their relationship with the patient, as well as whether the patient has a strong family support network; (7) past and current job history; and (8) the patient's interpretations of social support networks, stressors, and levels of functioning and disability.

If the patient is a recent immigrant, it is usually highly informative to ask about his/her adjustment to the host country. Most immigrants are enthusiastic to talk about their views of the United States, whether or not they have adapted well to the new environment and their jobs, whether they are satisfied with their lives, and whether they face obstacles in seeking help/care.

Mental Status Examination

Please refer to Kaplan and Sadock for a discussion of general components of a mental status examination, and to Hays for a discussion of complexities regarding mental status examinations for minority patients [26, 27].

DSM-5 Diagnoses

Psychiatric diagnoses are presented using the disorders in DSM-5. Despite the fact that some patients' explanatory models may not fit DSM-5 diagnostic categories, using this system of diagnoses facilitates communication among mental health professionals and insurance payers in the US healthcare system.

Culturally Sensitive Disclosure of Psychiatric Diagnoses

Disclosure of the psychiatric diagnosis to patients from diverse cultural backgrounds with traditional illness beliefs poses a great challenge clinically, since these patients tend to be less familiar with the concept of mental disorders, endorse stigma toward psychiatric problems and services, and interpret symptoms according to their cultural-specific beliefs [14]. The EIP approach to the culturally sensitive disclosure of psychiatric diagnoses is informed by anthropological literature and the experience of our team. It includes the following components: (1) eliciting patient's illness beliefs as described in the "History of Present Illness" Section above, (2) accepting multiple explanatory models, (3) reframing Western psychiatric concepts, (4) clarifying the meanings of diagnostic labels, (5) using flexible terminology, and (6) disclosing diagnoses and treatment approaches in stages. Below we give an example of using this framework with the immigrant Chinese American population when the clinician diagnoses the patient with major depressive disorder.

1. Eliciting the patient's illness beliefs:
   As described above, the EIP elicits patients' beliefs about their interpretation of their illness: what caused and triggered it, how it affects their lives, and what they consider good remedies for the illness.
2. Accepting multiple explanatory models:
   When patients' explanations of their illness differ from the ones offered or contended by Western medicine and psychiatry, clinicians are encouraged to take an accepting stance. Instead of asserting the Western conceptions of the illness, clinicians could use patients' explanations as the basis for discussing treatment rationale and expected outcomes, since such explanations are meaningful for them.
3. Reframing Western psychiatric concepts:
   If patients are familiar and comfortable with conventional psychiatric diagnoses, reframing may not be necessary. Very commonly, however, patients from other cultures may not share those conceptualizations of psychiatric illness. In our previous study of depressed Chinese immigrants, when the patients were asked for a reason for their illness, 55% responded, "I don't know." The rest of the patients attributed their symptoms to medical causes, interpersonal issues, or magical forces [28]. Thus, with Chinese immigrants, the monoamine hypothesis of depression might be framed as an imbalance of chemicals in the brain due to stress. This explanation would be readily understood because it overlaps with Yin and Yang theory in traditional Chinese medicine. According to this framework, an antidepressant would act to relieve symptoms such as sadness, insomnia, and fatigue by restoring balance to the system, by tonifying (补脑 bu. nao), or by strengthening the energy of the brain. Similarly, relating the concepts of "balance" and "imbalance" to the patient's interpersonal life and physical condition would be another way to tailor Western psychiatric concepts to fit within a contextual, family-centered, physical/somatic framework for Chinese patients. None of these explanations runs contrary to modern psychiatric thinking; rather, these reframings make the explanations more accessible and familiar to the patients.
4. Clarifying the meanings of diagnostic labels:
   Many non-Western immigrants tend to associate all psychiatric terms with insanity. It is important to explain to them what a specific psychiatric diagnosis means. Using again the example of communicating the diagnosis of major depressive disorder, one useful approach is to say, "You have reported having symptoms like sadness, sleep disturbance, loss of interest, blaming yourself, loss of appetite and being irritable. In Western medicine, these symptoms are called depression."
5. Flexible use of terminology:
   In our experience working with Chinese immigrants, the choice of Chinese translations of psychiatric disorders is very important to avoid stigmatized connotations. To avoid being too technical, Western clinicians often use the more colloquial term "depression" rather than "major depressive disorder" when working with English-speaking patients. With Chinese-speaking patients, there are several choices of translation. Strictly translated into Chinese, the term "major depressive disorder" becomes zhong xing you yu zheng (重型忧鬱症), which literally means "severe depressive disorder." In practice, clinicians or their Chinese interpreters often use the terms you yu zheng (抑鬱症), or yi yu zheng (忧鬱症), which would be translated as "depressive disorder." We suggest using an even more general term such as you yu (忧鬱), or "depression," which, like

its English equivalent, can refer to both a normal variation of mood as well as a pathological state. This term would be more acceptable to many Chinese immigrants who are less acculturated and is analogous to the use of the more colloquial term "depression" rather than "major depressive disorder" with English-speaking patients in the West.

Going even further, it might be acceptable to avoid mental health jargon all together and use simple descriptive language. One example might be to inform a patient that "all your personal problems have taken a toll on you, and now you are feeling sad and tired which also bring along other symptoms that you are experiencing." While we propose using flexible terminology, at least in the initial visits with patients when they are unfamiliar with technical terms, we would like to emphasize that clinicians should still be truthful. We encourage clinicians to use plain language and a conceptual common ground in co-constructing explanations for the illness, which may lead to a more successful negotiation of treatment (see below). We do not support using deceptive terms with patients, since this would be ethically unacceptable and could jeopardize trust between clinicians and patients.

6. Disclosing diagnoses and treatment approaches in stages:

   The technical term for the psychiatric diagnosis can and should be offered to the patient, as it is a legal requirement for full disclosure. On the other hand, such disclosure should happen after the correct concepts and nature of the illness have been communicated to minimize stigma and surprise. At that point, the diagnostic term can be presented in a way that is culturally resonant.

A Customized Approach to Treatment Negotiation

After exploring the patient's illness beliefs about the illness and taking the necessary steps to disclose the patient's diagnosis, the clinician enters into the treatment negotiation. Treatment negotiation empowers the patient and shows that the clinician respects the patient's point of view; in a practical sense, it may facilitate engaging patient into treatment. Clinicians may start by providing the rationale for treatments, usually aimed at alleviating patents' suffering and reducing the functional impairment caused by the medical/psychiatric conditions that prompted the visit. Clinicians should then discuss available treatment options, provide the rationale for and pros and cons of each treatment, and inform the patient of possible side effects [13]. If the patient is reluctant to initiate pharmacological or psychological treatment, then reassurance and clarification of underlying fears or worries about treatment are frequently helpful. Since many patients come to the clinic with specific illness beliefs, needs, and requests in mind, clinicians need to be open-minded and flexible to allow open communication between patient and clinician [14]. Negotiation between patients and practitioners over salient conflicts almost always contributes to more empathic and ethical treatment. The questions from the History of Present Illness section, "What kind of treatment do you think you should receive?" and "What are the most important results you hope to receive from the treatment?," provide the background information for treatment negotiation.

Part of treatment negotiation may involve exploring the patients' understanding of as well as preference for medication treatment, counseling, and other treatment measures, and to clarify misconceptions or worries (e.g., "can counselors keep things confidential") that might exist. For example, many Chinese immigrants are not familiar with psychotherapy treatment, what it entails or how it could be helpful to them. On the other hand, a fraction of Chinese immigrant patients who are emotionally overwhelmed actively seek "talk therapy" for their need for catharsis, emotional support, and guidance. Many of them have heard of and like the term counseling "心理辅導" (xin li fu dao), which connotes psychological guidance or coaching. Other patients may have a preference against medication treatment. For example, many Chinese immigrants either consider psychotropics to be treatment for the insane or question the usefulness of medications for solving their psychosocial problems, the focus of their worries. We find that the concept of imbalance of neurotransmitters in the brain triggered by stress and/or depression is helpful for framing this discussion and is well received by many Chinese Americans, probably because it is similar to the concept of imbalances of yin and yang, a cornerstone of Chinese philosophy.

The negotiation may end up with a compromise, which could be closer either to the patient's or the doctor's position. If for technical or ethical reasons the physician is uncomfortable with the compromise, referral should be made to another practitioner. It is important to maintain honesty, to accept criticism, and to be open to discussing one's uncertainty and the limits of one's understanding.

Case Vignette

In the following section, we use a case vignette of a Chinese patient who fit the DSM-5 criteria for major depressive disorder as an example of how to adopt a patient's illness beliefs in disclosing the patient's illness and in negotiating treatment. Identifiers have been changed and histories merged to protect patient confidentiality.

Case Vignette: A Patient with a Chief Complaint of Heartburn

The patient was a divorced Chinese female in her forties who immigrated to the United States about 5 years ago. She worked as a waitress in a restaurant and reported that her job and her relationships at work were fine. She started to experience heartburn 2 months ago. Her primary care physician saw her for a checkup and referred her for a consultation. When asked specifically about depressive and neurovegetative symptoms, she reported having depressed mood, insomnia, loss of interest, guilty feelings, and irritability. Upon further investigation, she reported that her sister recently passed away due to an illness about 2 months ago. She also expressed significant worries about tension with her teenage son, who had been having difficulties at school.

Patient's Explanatory Model of Her Illness Experience or "PERCEPTS"

1. **P**roblem?: "heartburn"
2. **E**tiology?: "not sure"
3. **R**emedy?: "If tension with my son is resolved, I will be fine"
4. **C**all the problem?: "heartburn, possibly depression"
5. **E**ffects on you?: "Heartburn, sadness, tired"
6. **P**erturbed (or fear) the most: "my son is not doing well"
7. **T**rigger: "sister passed away recently"
8. **S**everity: "pretty bad"

Culturally Sensitive Disclosure of Diagnosis

The patient did not label her problems as depression, and she focused on her physical symptoms. Yet when she was asked about specific depression symptoms, she acknowledged having many of them. She believed that her symptoms were due to worries about her son. With some guidance, she was able to see that tension with her son had been distressing to her, and that the death of her sister actually moved her off-balance. We acknowledged the discomforts from her heartburn but reassured her that her primary care physician had already performed the necessary tests and that the risks of having problems in her heart or stomach was low. We pointed out that when people were under a lot of pressure, acid from the stomach could rise up and cause heartburn sensations. We asked her if she had heard of depression (yi yu zheng) and whether she might be suffering from depression. She replied that she was not familiar with the term and she was not sure if she had the illness. We informed her that while it might be too early to conclude, there might be a possibility that she actually had depression.

Customized Approach to Treatment Negotiation

In negotiating treatment, she was informed that there are medications available to reduce her worries as well as her other related symptoms, including heartburn, sadness, insomnia, loss of interest, and irritability. We informed her that tension between her and her son could be lessened if her mood improved and she had more energy and resources to educate him. Possible side effects of this class of medications were discussed. The patient agreed to try the medications and see if they could help her. She was prescribed mirtazepine at the end of the interview.

Incorporating the EIP in Clinical Interventions

In our initial field testing with depressed Chinese immigrants, the EIP model was found to be a practical tool that can be completed within the allotted 1-hour time frame and was highly effective in facilitating the enrollment of patients in treatment for depression [27, 28]. The EIP has also been more recently incorporated in a culturally focused psychiatric (CFP) consultation service for Latino Americans [29, 30]. In a randomized, clinical trial of 118 Latino Americans with depressive symptoms, 85% of participants responded positively to all questions of the satisfaction scale. In in-depth interviews, the vast majority of participants reported the program met expectations, all stated providers were culturally sensitive, and most stated recommendations were culturally sensitive [30]. In addition, depression symptom reduction was greater among CFP intervention participants (mean ± SD change in QIDS-SR score = 3.46 ± 5.48) than those in usual care (change = 0.09 ± 4.43) [31]. These results suggest that Latino Americans experiencing depressive symptoms found this treatment negotiation approach of the EIP acceptable, and that this underserved population may benefit from a short-term CFP consultation using the EIP [32, 33].

Conclusion

Culture plays an important role in influencing the formation and presentation of psychiatric problems and patients' illness beliefs. The EIP is a practical tool that incorporates cultural components into the usual psychiatric assessment format and is designed to fit into a standard 1-hour initial psychiatric evaluation. The EIP explores patients' cultural explanations of illness by eliciting patients' narrative descriptions and used structured illness-belief questions. The EIP also uses standardized items to elicit patients' psychosocial history and generates information on patients' cultural identity, psychosocial environment, and levels of functioning.

By providing a more complete understanding of the patients' cultural background, the EIP may improve communication between practitioners and their patients and enhance culturally sensitive disclosure of psychiatric diagnosis and engagement of patient into psychiatric treatment. Initial trials using the EIP in Chinese American and Latino American underserved populations with depressive symptoms have been promising. Future applications of the EIP may be broadened to include a variety of medical, research, and educational settings and may enable a variety of professionals to more effectively communicate with the populations they serve.

The Engagement Interview Protocol (EIP)

I. History of Illness
  A. History of present illness
    Patient's narratives on personal illness experience
    Patient's cultural explanatory of his/her illness: ("PERCEPTS")
    1. What is the **P**roblem which bothers you?
    2. What is its **E**tiology?
    3. What do you think is a good **R**emedy or treatment?
    4. What do you **C**all the problem?
    5. What is its **E**ffects on you?

        6. How much are you **Perturbed** (or do you fear) by the problem?
        7. What do you think **Triggered** the problem?
        8. How **Severe** is the problem?
    - B. Past psychiatric/medical history
    - C. Family history
- II. Psychosocial History
    - A. Past psychiatric/medical history
    - B. Family History
    - C. Immigration history
      The date, purpose, and process of immigration; adjustment in the host country
    - D. Marital history
    - E. Spiritual/religious beliefs
    - F. Family support network:
      With whom do you live?
      How is your relationship with your spouse, parents, siblings, children, etc.?
    - G. Past and current job
    - H. Social supports
    - I. Stressors
    - J. Levels of functioning
- III. Mental status examination
  Appearance:
  Attitude:
  Behavior:
  Speech:
  Motor:
  Mood:
  Affect:
  Thought process:
  Thought content:
  Perception:
  Cognition and intellectual resources:
  Insight/judgment:
- IV. DSM-5 Psychiatric diagnoses
- V. Culturally sensitive disclosure of diagnosis
    - A. Elicit the patient's illness beliefs
    - B. Accept multiple explanatory models
    - C. Clarify the meanings of diagnostic labels
    - D. Sensitive and flexible use of terminology
    - E. Disclose in stages
- VI. A customized approach to treatment negotiation
    - F. Explore the patient's understanding and preferences for treatment
    - G. Discuss the pros and cons of treatment options
    - H. Negotiate and finalize treatment plan
    - I. Discuss potential side effects from treatment and possible remedies

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3 Cultural and Diversity Issues in Mediation and Negotiation

David Alan Hoffman and Katherine Triantafillou

This chapter is excerpted and adapted from a chapter by the same authors in David Hoffman et al., *Mediation: A Practice Guide for Mediators, Lawyers and Other Professionals* (Massachusetts Continuing Legal Education 2013). A series of asterisks marks the location of material deleted from the original version.

The terms “mediation” and “negotiation” are used interchangeably in this article, although they are distinct concepts. Mediation is a process whereby a neutral facilitator helps two or more people in a dispute resolve that dispute through dialogue. Negotiation is essentially the dialogue that two or more people have regarding an issue in which they wish to reach an understanding or agreement.

Introduction

Mental health professionals often engage in professional work that resembles mediation and negotiation. Whether in the form of couples counseling, family therapy, parent–child counseling, or simply the setting of boundaries and ground rules in individual psychotherapy, mental health practice has much in common with the work that mediators do. In this chapter, we offer the perspectives of two practicing mediators on a subject that is critical to the work of both mediators and mental health professionals—namely, cultural and diversity issues.

Mediators routinely encounter racial, cultural, and other forms of diversity in their work, and therefore no curriculum of mediation training would be complete without consideration of the challenges (and opportunities) that accompany such diversity. In the Massachusetts Uniform Rules on Dispute Resolution, cultural diversity is listed as one of the “critical issues” in the training curriculum required for court-approved mediation programs [1].

Mediation is sometimes described as “making a safe place for a difficult conversation.” Mental health professionals are often engaged in that same process, and among the things that make conversations difficult are the differences described in this chapter.

Although we cannot treat this subject exhaustively in one chapter, we can offer perspectives—both our own and those of experts in the field—as an introduction to some of the diversity issues that arise in mediation.

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The Seeds of Difference

The word "barbarian" in ancient Greece was used to delineate between those who were born Greek and those who were not; those who spoke Greek properly and those who did not; and later, those who were considered to be civilized (the Greeks) and those who were not (the Persians). Throughout history we encounter countless examples of how humans have differentiated themselves from each other, whether it is based on country of origin, race, religion, tribe, or language, to name just a few of the familiar lines of demarcation.

Had anyone told the ancient Greeks that the use of the word "barbarian" was discriminatory or prejudicial toward non-Greeks, they probably would have snorted in disdain. In those times, being able to identify who was an outsider and who was not often became a matter of life and death. The homogenous character of the modern Greek state, like many European states, is beginning to change. However, different ethnicities in Greece are oftentimes greeted today in much the same way as they were in Plato's time, as Greece struggles to integrate refugees from Pakistan, Afghanistan, Bangladesh, and Sudan.

While Buddhists teach that we are all from the same cosmic soup and therefore share a common humanity, most of us have ingrained reactions to people who are different from us. (See discussion below regarding "implicit bias.") Every nation or culture has a "them"—the dreaded "other" that represents a real or imagined threat to its safety. And every individual makes thousands of split-second judgments about his or her environment and the people who inhabit that environment, engaging in a type of cultural shorthand that makes negotiating daily life easier. For example, when we encounter someone who is fashionably attired and driving a Maserati, or someone who looks dirty and disheveled, carrying an empty cup, and asking for handouts, we make unavoidably hasty judgments—at what point do those judgments veer into the territory we call "prejudice" or "bias?" At what point do those judgments inhibit us from experiencing the people in our world with an open mind and an open heart?

One of the primary roles of the mediator (and mental health professional) is to be impartial regardless of the parties' circumstances and differences and to bring an open mind and heart to the process. And yet mediators often find themselves feeling more sympathetic to one party than another, even while they exhibit behavior that the parties view as impartial. Moreover, experience quickly teaches mediators that the parties do not meet on a level playing field—one in which the disputants are fairly equal in power and information or can be made equal by a process that shares information and incorporates or acknowledges difference in ways that promote good communication. All too often, differences create advantages and disadvantages at the bargaining table—some of them reflecting a differential in the parties' resources, and some of them internalized attitudes of superiority on the one hand or fear and disempowerment on the other. In addition, people come to the mediation table with vastly different life experiences—some of them the result of mistreatment based on race, gender, or other characteristics. Or, the parties may have positive feelings about their differences—for example, a person's ethnic, regional, or racial heritage may be a source of pride and may even be celebrated by society as a whole.

Even if the disputants are two white middle-aged educated individuals who live in the same city, work for the same corporation, and ostensibly speak the same language, sometimes they are *not* speaking the same language, especially when one is a male and one is a female complaining about sexual harassment. Or, if one disputant comes from a family that reveres holidays and has numerous memories of happy gatherings with smiling faces and the other comes from a family whose dysfunction was especially acute during the holidays with excessive drinking or violent episodes and broken furniture, will they approach the task of constructing a parenting schedule for the holidays in the same way? If the mediator's family holidays were centered on somber religious activities, how will that affect the mediation of that schedule? What if the mediator has an incest history, the bulk of which occurred during family holidays?

Given the vast differences that make up who we are as human beings, is it possible to truly manage differences sufficiently to ensure the process is fair to the participants? Can we empower participants sufficiently that their past experiences are not a barrier to meaningful mediation?

There are no easy answers to any of these questions, no boilerplate checklists that will provide the correct path through the maze that we call diversity and inclusion. The purpose of this chapter is to point mediators and mental health professionals in the right direction and to suggest the types of questions we might ask ourselves and the parties about our differences.

Mediation and the Problem of Bias

One of the persistent criticisms of mediation is that bias is less controllable in informal forums, and thus the preferred method of dispute resolution in cases where such bias is a factor is litigation, where there are strict rules of procedure, a public forum, and a judge to oversee the process [2]. This is an argument frequently put forward by gender specialists who caution that the use of mediation, especially mandatory mediation, is counterproductive, even harmful, given the power imbalances that often exist between men and women in our society. The late Trina Grillo, a law professor known for her gender-based critique of mediation, makes the argument forcefully:

> Mandatory mediation can be destructive to many women and some men because it requires them to speak in a setting they have not chosen and often imposes a rigid orthodoxy as to how they should speak, make decisions, and be. This orthodoxy is imposed through subtle and not-so-subtle messages about appropriate conduct and about what may be said in mediation. It is an orthodoxy that often excludes the possibility of the parties speaking with their authentic voices. Moreover, people vary greatly in the extent to which their sense of self is "relational"—that is, defined in terms of connection to others. If two parties are forced to engage with one another, and one has a more relational sense of self than the other, that party may feel compelled to maintain her connection with the other, even to her own detriment. For this reason, the party with the more relational sense of self will be at a disadvantage in a mediated negotiation [3].

Professor Deborah Kolb and researcher Gloria Coolidge explore these gender differences by focusing on how men and women tend to negotiate differently [4]:

> Women speak differently. Their assertions are qualified through the use of tag questions and modifiers … the female pattern of communication involves deference, relational thinking in argument, and indirection. The male pattern typically involves linear or legalistic argument, depersonalization, and a more directional style. While women speak with many qualifiers to show flexibility and an opportunity for discussion, men use confident, self-enhancing terms.
>
> Anticipating that assertiveness may lead away from connection, women tend to emphasize the needs of the other person so as to allow that other person to feel powerful. Her behavior may thus appear to be passive, inactive, or depressed.

Professor Linda Babcock performed experiments with men and women as advocates for themselves and others in salary negotiations and found that women tend to be less forceful advocates for themselves but are more forceful when advocating for others. For men, the pattern was the opposite—they were more assertive than women when advocating for themselves and somewhat less so when advocating for others [5].

This is one of the primary reasons why domestic violence experts are adamantly opposed to the use of mediation. Aside from the physical risk of continued close contact, in order for a battered spouse to *leave* the batterer, she must overcome societal and internal expectations that she *stay* to keep the family intact. Engaging in mediation during that crucial period when an abuse victim has finally broken through her silence and publicly acknowledged being battered can easily retard the victim's nascent sense of independence and selfhood. In addition, the informality of mediation allows the batterer the opportunity to continue the psychological manipulation inherent in the relationship, frequently impressing the neutral party with his normalcy, charm, or erudition. It can also cause the victim to distrust her own instincts for survival. This is especially true when mediation is focused on the *present* and participants are admonished to ignore *past* conduct or assured that the forum will be "judgment-free." Victims of domestic violence *need* judgments made about the abuser in order to disentangle themselves from a horrible situation. Thus, a mediated agreement may be "fair," but as some authors point out, it may not be "just."

The impact of bias and power imbalance described above with regard to gender can be seen in the areas of race, ethnicity, culture, sexual orientation, age, religion, socioeconomic class, disability, and other factors that affect the mediation process. Although empirical research about this impact is still in its early stages, the results thus far suggest that diversity issues affect outcomes in mediation.

One of the frequently cited studies involved comparing the outcomes of adjudicated cases and mediated cases in the Bernalillo County Metropolitan Court in Albuquerque, New Mexico [6]. Using approximately 600 cases, the evaluators attempted to discern whether women and minorities "would do more poorly … because mediation is a less formal, less visible, and less controlled forum than adjudication" [7]. The study focused on both subjective and objective outcomes and found that minority disputants received less money than nonminority litigants in adjudicated cases *and* mediated cases, with the latter being "more pronounced." While some of the variation was due to other "case characteristics," such as the claimant being a lawyer or represented by a lawyer, the study essentially concluded that mediated outcomes for minorities were less favorable than for nonminorities. However, on subjective scales, such as satisfaction with the process, "minority claimants were consistently more positive about mediation than they were about adjudication." What is most interesting about the study, however, is that the measured effects of bias in objective outcomes (less money received or more money paid) were dramatically altered if the mediators were members of the minority group—in other words, minority disputants achieved better results in mediations with minority mediators [8].

With regard to women, the study found that gender had no direct effect on monetary outcomes, whether the case was mediated or adjudicated. However, white women were more satisfied with the adjudication process than with mediation and "less likely to see the mediation process as fair and unbiased" [9], while minority women were more satisfied with mediation. Furthermore, minority participants in mediation continued to express greater satisfaction with the process over time [10].

Understanding Patterns of Oppression and Discrimination

Discrimination in Negotiation

It is hardly surprising that diversity issues impact the results of mediation. Discrimination has been a persistent feature of commerce in the United States since our nation's inception and before. Racial discrimination in housing and employment, for example, has been widely documented long after the enactment of civil rights legislation designed to end such practices.

In one famous study of discrimination in the commercial arena, reported in an article entitled Fair Driving: Gender and Race Discrimination in Retail Car Negotiations published by the *Harvard Law Review*, testers used a uniform negotiation strategy to bargain for the purchase of a new car at 90 dealerships in the Chicago area [11]. The testers were white and black, women and men. The article's author—economist, lawyer, and business professor Ian Ayres—found that the offers made by salespeople were biased by both the race and gender of the buyers (Table 3.1).

Gender-based discrimination was also convincingly demonstrated in studies involving auditions for symphony orchestras. In 1970,

Table 3.1 Gender and race discrimination in car sales

	White male	White female	Black male	Black female
Average dealer profit based on initial offers by the dealer ($)	818	829	1534	2169
Average dealer profit based on final offers by the dealer ($)	362	504	783	1237

female musicians comprised only 5% of the musicians in the top five symphony orchestras in the United States. Under pressure to increase this number, the orchestras instituted new procedures involving the use of "blind auditions" in which prospective performers played behind a screen so that the judges could not see them. This produced a fivefold increase in the number of women who won places in those orchestras [12].

Race and gender are, of course, not the only factors that affect negotiations, hiring decisions, and the way people treat each other. Research has shown that physical appearance can produce both positive and negative biases. Taller people get paid higher salaries, on average, than short people [13]. Unattractive people also face bias in employment [14], and, according to one study, physical attractiveness can produce a significant boost in salary [15]. Even in the realm of criminal law, attractiveness plays a role: one study has shown that criminal defendants who are viewed as less physically attractive risk harsher sentences [16], Even within racial groups, physical appearance can affect sentencing: "Analysis of a random sample of inmate records showed that Black and White inmates, given equivalent criminal histories, received roughly equivalent sentences. However, within each race, inmates with more Afrocentric features received harsher sentences than those with less Afrocentric features" [17].

Moreover, it is difficult for white people to deal effectively with their unacknowledged racism. The guilt attendant to such unexamined feelings frequently clouds our perceptions and good intentions/actions. As much as we would like to think we are "color blind," if we grew up in the United States, we have racial baggage—regardless of our race. Professor Peggy McIntosh, a women's studies expert, makes the point quite effectively when she states the following in an essay entitled White Privilege: Unpacking the Invisible Knapsack [18]:

> I have often noticed men's unwillingness to grant that they are overprivileged, even though they may grant that women are disadvantaged … As a white person, I realized that I had been taught about racism as something that puts others at a disadvantage, but had been taught not to see one of its corollary aspects, white privilege, which puts me at an advantage.

McIntosh continues her self-assessment with a list of the "daily effects of white privilege," among them the following:

- I can go shopping most of the time, pretty well assured that I will not be followed or harassed.
- I am never asked to speak for all the people in my racial group.
- If a traffic cop pulls me over or if the IRS audits my tax return, I can be sure I haven't been singled out because of my race.
- I can take a job with an affirmative action employer without having coworkers on the job suspect that I got it because of my race.
- If my day, week, or year is going badly, I need not ask of each negative episode or situation whether it has racial overtones.
- I can worry about racism without being seen as self-interested or self-seeking.

No one likes to think of themselves as biased, but reading that list, or making up your own, certainly highlights the ways in which the lives of white people in our society differ from the lives of African-Americans, notwithstanding the laws that prohibit discrimination of various kinds [19].

The phenomena described above with regard to race apply with equal force in connection with gender, culture, sexual orientation, and other characteristics. Although some indicia of discrimination have improved (e.g., pay gaps between men and women have narrowed somewhat), disfavored groups still suffer a variety of disadvantages in our society, and the favored groups still, for the most part, struggle with acknowledgement of their advantages.

There is a paradoxical aspect of cultural competence for mediators—namely, that mediators are trained to look forward, and yet to be culturally competent requires an understanding of the past and in particular the ways in which oppression has shaped the experience, values, beliefs, and emotional reactions of nondominant groups.

Internalized Oppression

Discrimination takes its toll internally, as well as externally. In the landmark school desegregation case of *Brown v. Board of Education* [20], the Supreme Court cited as support for its opinion psychological studies showing that African-American children had internalized a sense of inferiority—for example, preferring white dolls rather than dolls with darker skins and attributing more positive characteristics to the white dolls. Based on this "doll test" and similar tests of children, the studies concluded that prejudice, discrimination, and segregation caused black children to develop a sense of inferiority and self-hatred. Citing this study with approval, the Court stated that segregating black children from white "solely because of their race generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone" [21]. Today, de jure segregation is illegal, but patterns of housing and school assignment still relegate too many African-Americans de facto to an essentially segregated world.

A related phenomenon is that of "internalized homophobia," experienced by lesbian and gay individuals who internalize the prejudices of a heterosexist society. "Stigmatized individuals engage in defensive reactions as a result of the prejudice they experience and thus incorporate a unique form of psychological distress" [22]. One of the obvious stressors is being "in the closet"; however, unlike other oppressed groups, LGBTQ people also risk being shunned by their families or religious groups and must actively seek out new or alternative social networks that validate their existence [23].

Another form of internalized oppression can be seen in a phenomenon known as "stereotype threat" [24], which can undermine the performance of people who are members of groups that are negatively stereotyped [25]. This phenomenon occurs even if there is no overt stereotyping taking place. According to several studies, stereotype threat "undermines performance by creating distraction" and produces this effect in both laboratory and real-life settings. An example of this phenomenon was found when measuring the performance of women in chess matches in which the identity of the opponent was hidden from the players [26]. In comparison to their rated strength, the women played worse when told that their opponents were men and that men are better chess players than women. When women players were told that they were playing against women, their performance improved, regardless of whether their actual opponents were men or women.

In another experiment, a group of African-American test-takers who were asked to indicate their race at the beginning of the verbal portion of Scholastic Aptitude Test performed substantially worse than a comparable group of African-Americans who were not asked to indicate their race [27]. In other words, just reminding someone of a racial difference may be a trigger that affects performance. In a similar test involving math skills, asking Asian-American women questions that evoked consciousness of their race at the beginning of the test produced *higher* test scores, while asking them questions that evoked consciousness of their gender resulted in lower test scores [28].

Internalized oppression can also produce physical effects. In 2007, *The Boston Globe* reported on the growing body of evidence—more than 100 studies, most published since 2000—showing the negative effects of racial discrimination on physical health, including heart disease and stroke [29]. This phenomenon has been found outside the United States as well [30]. An epidemiologist at the Harvard School of Public Health, Nancy Krieger, found that these health effects are worsened when the discrimination is not discussed or addressed in some manner [31].

For mediators, these studies suggest the importance of addressing discriminatory behavior or comments when they arise. Sometimes comments are made in mediation that the mediator fears might be experienced by others as discriminatory even if they were not intended that way. Under those circumstances, the mediator could meet with the parties separately to assess the situation and decide whether it seems advisable to address this issue directly.

Culture and Negotiation

In our discussion thus far, we have focused on the impact of difference in the context of bias and oppression. Mediators, we conclude, need to be keenly attuned to the impact of such differences because of their potential impact on the mediation process. For example, a party who feels demeaned by an opposing party because of his/her race, class, ethnicity, or gender, may "shut down" and find it hard to participate fully in the mediation. (In several sections below, we discuss interventions that a mediator can use in such situations.)

In this section we focus on cultural differences that do not always involve value judgments but may engender misunderstanding if not understood. For example, in some cultures, eye contact in a negotiation is considered aggressive, perhaps even offensive, while in other cultures the failure to make eye contact may be viewed as disrespectful [32]. These differences are akin to a difference in eating utensils: chopsticks are neither inherently better nor worse than silverware—just different. A vast array of cultural differences can complicate the work of peacemaking, if mediators are not sensitized to those differences and trained to deal with them effectively.

Cultural competence requires us to learn or at least become familiar with the "silent language," as Jeswald Salacuse calls it, of other cultures [33]—a task akin to learning a foreign language. We don't, for example, try to change how the Russians decline nouns; we accept it and endeavor to become more adept at communicating in that language.

Negotiation Styles

Professor Jeswald Salacuse focused his analysis strictly on negotiation and measured bargaining behavior, as reported by the negotiators, using the following matrix [34]:

1. Negotiating goals (contract or relationship?)
2. Attitudes to the negotiating process (win/win or win/lose?)
3. Personal styles (formal or informal?)
4. Styles of communication (direct or indirect?)
5. Time sensitivity (high or low?)
6. Emotionalism (high or low?)
7. Agreement form (specific or general?)
8. Agreement building process (bottom up or top down?)
9. Negotiating team organization (one leader or consensus?)
10. Risk taking (high or low?)

Professor Salacuse measured responses from individuals in 12 countries [35]. The results reflect significant variations from country to country. Some of the results seem predictable. For example, on Salacuse's "informal or formal scale," 83% of the Americans interviewed felt they had an informal negotiating style as compared to 54% of the Chinese negotiators and 53% of the Spanish negotiators. Cultures that negotiate similarly in one respect may diverge widely in another—for example, on the scale of negotiation attitude (win/win vs. win/lose), 82% of the Chinese negotiators describe their style as win/win, while only 44% of the Spanish negotiators do.

While the complete results of this study are too lengthy to include in this article, this brief description suggests why the participants in a mediation session might be approaching the task of problem-solving differently based on their cultural or ethnic background [36]. Even a reluctance to participate in mediation could be an indication of a cultural attitude, such as the Korean-Americans studied by Diane LeResche, who view "conflict as a negative situation […] represent[ing] a shameful inability to maintain harmonious relationships with others" [37].

It is not always easy to know whether cultural issues are impacting mediation or whether a mediator's assumptions about cultural behavior are getting in the way of successful communication. Mistakes will be made!

Along with complexities of negotiation style, mediators encounter a dizzying variety of communication styles—many of them culturally rooted. "Every country has its own way of saying things," according to the prolific travel writer

Freya Stark. “The important thing is that which lies behind people’s words” [38].

Cataloguing specific cultural variations in communication style lies beyond the scope of this chapter. Suffice it to say, however, that an astute mediator will be attuned not only to content (e.g., is the style direct or indirect?) but also facial expressions, eye contact (or the lack of it), body language, and gestures. Figures of speech do not always translate well from one culture to the next, and hand gestures can be particularly tricky. (For example, a thumbs-up gesture in American culture means approval, but in Arab cultures and South America, its meaning is vulgar [39]).

Gender as Culture

Researchers have long debated the question of whether male–female differences are learned or innate. For purposes of understanding and working with those differences, however, their origin is probably irrelevant. What matters is how we react to the parties in the mediation process and how they react to each other. (In the discussion that follows, gender is discussed based on what sociologists find as the center of the bell curve, and, as in other descriptions of cultural norms, exceptions, and outliers abound.)

Among recent conceptual breakthroughs in our understanding of how gender affects our experience, perspectives, and social interactions, two stand out: Professor Carol Gilligan’s research about the development of ethical norms [40] and Professor Deborah Tannen’s research about gender differences in the way people communicate [41]. Gilligan found that boys tend to develop attitudes about ethics based on rule-based ideas of right and wrong, whereas girls tend to develop attitudes that are more contextual and relational. Tannen found that women’s conversational styles were more personal, relational, and focused on understanding, while men’s were focused more on information, advice, and status/power. Neither Gilligan nor Tannen argued that the norms of one gender are “better” than the other’s (quite the opposite)—instead, their point was that these differences, if not identified, become sources of misunderstanding, judgment, and blame.

Research reported by Dr. Pat Heim shows that these differences are not surprising, because boys and girls grow up in different “cultures” with differing expectations about how to behave and how they will be treated [42]. These differences begin early in life. Infants wrapped in blue blankets are handled differently than infants wrapped in pink blankets. The leading children’s books—those that have won the coveted Caldecott medal—show ten males in positions of leadership for every female in such a role. The studies summarized by Heim show that games that boys tend to play (war, cops and robbers, football) are essentially hierarchical, competitive, goal-oriented, and often team-based, while the games that girls tend to play (dolls, house) are typically based on one-on-one connections, cooperation, and “flat” (as opposed to hierarchical) relationships. Although winning is the sole point in boys’ games, according to Heim, boys, on average, lose as often as they win and therefore learn to mask their emotions, because showing sadness as a result of a loss would be considered “unmanly.” In girls’ games, there tend to be no winners and losers, and girls learn the importance of “being nice” and “getting along” [43].

To be sure, the upbringing of girls and boys has changed in the United States in recent years, and today more girls than ever are involved in competitive team sports (due in no small measure to the enactment of Title IX). However, social scientists continue to see substantial differences in how men and women behave, how they communicate, and how they fare in business [44]. At the same time, these different “cultures” get blended to some degree as adults, since occupational roles influence behavior. For example, law has often been described not only as a male-dominated profession (though this is changing) but also as a profession in which typically male “norms” hold sway. To use Gilligan’s typology, successful arguments in the legal arena are typically based on rules of general applicability (and concepts of right and wrong) rather than contextual and relationship-based norms.

The bottom line, as we try to understand the ways in which gender operates as a "cultural" difference, is that one culture is not better than the other. Chopsticks are not better than silverware, nor is it essential that one culture learns to use the utensils of the other. Rather, the point—for mediators and others—is to destigmatize the difference.

The LGBTQ movement has also expanded society's understanding of what gender means and how it relates to sexual orientation and human biology. According to traditional views on these subjects, gender and sexual orientation are binary: one is either male or female, and one is attracted to men or to women. A more nuanced and accurate view is that there are at least four components: (a) biological sex (based on physical characteristics); (b) gender identity (how we think about ourselves on a scale that ranges from "woman" to "man" with "gender queer" in the middle of the scale); (c) gender expression (how we express ourselves by how we dress, behave, and interact); and (d) sexual orientation (to whom are we attracted). This broader understanding has also led to the use of the term "cis-gender," which (a) means that a person's gender identity corresponds to their sex assigned at birth and (b) is the opposite of transgender [45].

Confounding Variables: Psychological Issues and Social Dynamics

One of the joys of mediation is its inherent complexity. For people who enjoy challenges, it is an ideal occupation. The challenges presented by diversity issues are compounded when we take into account the psychology of the parties (and our own) and the social dynamics that influence behavior in the setting of mediation.

A case in point: a middle manager is fired by his employer for abrasive communications with his colleagues and supervisors. He sues the employer, alleging national-origin discrimination (he is from Eastern Europe). In the mediation of this dispute, the employee negotiates in a manner that seems unusual to the mediator. The employee lowers his demand and then raises it again. Operating from a framework of North American assumptions about typical negotiating behavior, the mediator concludes (probably inaccurately) that the employee's bargaining style is atypical because of cultural differences. The mediator encourages the employee to follow the lead of his attorney, who is very experienced in employment cases, but the employee resents this advice, fires his lawyer, and arrogantly asserts that he is a better negotiator than anyone involved in the case and therefore does not see why he should follow anyone's advice. In the end, the mediator concludes (after consulting with a psychologist) that the employee's behaviors indicate the possibility of a narcissistic personality disorder.

In this case, culture no doubt played a role in the negotiations. But because culture was the most obvious difference, it obscured a less visible but arguably more powerful factor—namely, a psychological issue that stood in the way of productive bargaining.

Social dynamics can also play a role. In most mediations, the parties are not alone—they are part of a social matrix that influences their bargaining behavior. In divorce mediations, for example, each spouse usually receives advice and encouragement from an assortment of friends and relatives, not to mention professional advice from lawyers and therapists. Not surprisingly, the parties feel accountable to some degree to these constituencies of supporters. Thus, while the mediator tries to understand the unique aspects of each of the parties (cultural, gender, psychological, or other), s/he may not realize that there are a host of other people in the wings, each with their own complicated backgrounds and psychological orientations. To the extent that each of the parties in the mediation is driven by a desire not to lose face with these supporters, it becomes necessary for the mediator to understand the cultural orientation and goals of those supporters.

Another case in point: a college freshman has died in a fraternity hazing incident, and his parents are now suing the fraternity, its parent organization, the owner of the fraternity's building, several individuals involved in the incident, and all of the relevant insurers. The family is demanding $10 million as a settlement. The mediator is meeting with the defendants—11 parties in all. Everyone in the room agrees that their initial offer of settlement needs to be no less than $1 million, or else the plaintiffs will likely terminate the mediation. When each party is asked what they are willing to offer in this first round of negotiation, the collective sum is only $900,000. All of the defendants agree that it would be in their best interest to come up with another $100,000 in order to keep the mediation on track, but no amount of reasoning and cajoling from the mediator breaks this deadlock. The mediation ends, and the case proceeds to litigation. Why were the defendants deadlocked? The mediator concludes that there were two sets of social dynamics that overwhelmed rationality. First, in the conference room, each of the defendants was seeking to communicate its resolve to the other defendants. Even though there was virtually no chance that the defendants' initial offer would be accepted, none of the defendants wanted to "blink," because of the precedential effect that could have been had in subsequent rounds of bargaining. Second, and equally important, all of the defendants (and particularly the corporate defendants and insurers) were merely representatives of complex organizations with their own unique cultures and values. These representatives may have felt that they needed to avoid losing face with their constituencies back at the office. (One common observation about negotiation dynamics is that the toughest bargainers are those who are farthest from the table.)

In short, mediators need to remember that, even if they believe they understand how culture, class, race, ethnicity, gender, sexual orientation, and other factors may be influencing the individual parties in the room, each of the parties may also be influenced by unseen psychological and social dynamics involving people who are not present. Accordingly, mediators should inquire about those dynamics and try to understand how they are affecting the mediation process.

Practical Considerations for the Mediator

Given what we know about bias, how can the well-intentioned mediator guard against it both personally and with clients?

Developing Cultural Competence

One obvious place to start is to look within. Acknowledgement and self-assessment help us clear our minds of judgments about the parties.

Bias arises from learned attitudes and can be transmitted to those close to us or part of our group. And what can be *learned*, can be *unlearned*. This conclusion was documented in fMRI studies reported by the developers of the Implicit Association Test ("IAT"), an ongoing study sponsored by Harvard University [46]. Visitors to this site have completed more than 4.5 million tests [47], which explore their reactions to people based on their race, age, gender, weight, disability, and other characteristics. Based on this data, researchers have found, among other things, that 80% of Americans harbor negative attitudes toward the elderly and 75–80% of the white and Asian test-takers express preferences for whites rather than blacks. The developers of the IAT found that while we have automatic, immediate, unconscious reactions to people of a different race at the level of our amygdalas, those responses (not surprisingly) can be moderated by other parts of our brain that regulate our social interactions [48]. (The test gives new meaning to the expression, "The truth shall make ye free, but first it shall make ye miserable.")

Recognizing that bias is a universal phenomenon can lead us to both self-criticism and self-forgiveness. Both of these seemingly contradictory impulses are valid responses to the residue of bias that lingers in even the most conscientious and culturally competent mediators.

When Harvard psychology professor Mahzarin Banaji developed the IAT with psychologist Anthony Greenwald, she was surprised to find that she was biased against blacks—a particularly vexing phenomenon because she herself is a person of color. One of the techniques that she used to counteract her own implicit attitudes with regard to both race and gender was to display prominently in her office photographs of women and people of color whom she admired—George Washington Carver, Emma Goldman, Miles Davis, Marie Curie, Frederick Douglass, and Langston Hughes [49].

Perhaps an even more profound change may come from widening and deepening the circle of connection in each of our lives. All too often, those in our circle of friends and colleagues look a lot like us. Mediators can make a conscious choice of involving a wider circle of colleagues in our professional work through self-reflection and peer supervision groups. And even within our existing circles of friends and colleagues, we often fail to explore deeper levels of understanding of people who are different from us.

Here is an exercise in overcoming our own implicit bias described by Professor Banaji:

> Just before Halloween, Banaji says, she was in a Crate & Barrel store when she spied a young woman in a Goth outfit. The woman had spiky hair that stuck out in all directions. Her body was pierced with studs. Her skull was tattooed. Banaji's instant reaction was distaste. But then she remembered her resolution [to engage with people she might otherwise have avoided]. She turned to make eye contact with the woman and opened a conversation [50].

Cultural competence involves more than freeing our minds of bias—it requires affirmatively seeking to understand the people we encounter in the mediation process and elsewhere. Curiosity is key. If participants are from a country or ethnic group outside your experience, spend some time reading about that culture [51]. If the person's background or ethnicity is not apparent, do not be afraid to ask background questions that will aid your work. Avoid stereotypes—for example, do not assume that all people from a particular country or culture are likely to have the same negotiating style.

Respect for the parties is a crucial element of cultural competence. One key element of such respect is pronouncing the parties' names correctly and adopting a form of address that is comfortable. Many mediators prefer working with the parties on a first-name basis, because the informality contributes to a spirit of collaboration. However, first-name basis may be profoundly uncomfortable for people who are accustomed to a more formal manner of addressing people in a business setting. And it might also be uncomfortable to people who, because of cultural or power dynamics, have felt demeaned when called by their first names.

Finally, mediators need to bring enough humility to their work to be open to the possibility that some other mediator might be a better fit for the parties because of background or experience. (Also, see discussion below regarding co-mediation.)

The Mediator's Relationship with the Parties

An enigmatic story from Professor Michelle LeBaron about an informal mediation in a First Nations community in Canada captures one aspect of what mediators need to know to practice in a culturally competent manner:

- There was an elder who had a dog, and that dog barked all night long, every night, kept the whole neighborhood awake. It was a really yappy dog, and nobody could stand it much longer. One afternoon an elder went over to visit the dog owner without being announced. They had tea. Talked about the weather and the upcoming powwow. They told a couple of stories. Then the elder left. Still the dog barked at night. A few days later, the same elder dropped by for another visit. Same thing. They talked about the weather and the brushfire down in the coulee. Then the elder left. Still no relief. A day or two later, the elder visited again. They had tea. Talked about the weather, the way the government negotiations were going. And the elder left. After that, the dog was kept in every night. Never caused anybody trouble anymore [52].

Why did the two elders never discuss the dog? And how did the dog owner finally come to understand what was being asked of him/her—albeit inexplicitly? The essential element of the success of this intervention appears to be the recognition that the dog owner needed to avoid losing face in the community, and therefore direct confrontation about the dog might have been counterproductive. This story suggests that in this particular culture, a gentler, less direct form of negotiation was needed. A mediator who lacked an understanding of this feature of the parties' culture might have been more direct and less successful.

However, given the enormous variety of cultural and diversity issues that can arise in a mediation, how can a mediator manage those differences successfully?

Premediation Consultation, Planning, and Research

Mediators should generally consider and, in some cases, insist on a premediation consultation with the parties. In addition to such logistical considerations as who will be attending, how much time to reserve, and how the mediation fee will be allocated, mediators can ask about the parties, their backgrounds, and other information about them that will help the mediator prepare for the case.

These separate meetings provide an excellent opportunity to explore diversity issues in a safer setting. In family mediation, meeting separately with the parties can uncover power dynamics and cultural differences. The Internet also provides a vital opportunity to learn about the parties, their values, and their backgrounds.

Confronting Bias

As noted above, one of mediation's central tasks is making a safe place for a difficult conversation. If any of the parties feels demeaned—particularly as a result of his/her culture, class, ethnicity, gender, race, sexual orientation, disability, or other characteristics—the mediation will no longer feel safe. How, then, can a mediator prevent or respond to behavior that causes the mediation to feel unsafe in this way?

As noted above, preparation can sometimes head off trouble at the outset, by alerting the mediator to the relevant risks. The mediator might be informed that one of the parties is considered a bigot by the other parties. Or that one of the parties has a hard time treating women as equals. What might the mediator do in a separate meeting with one or more of the parties to neutralize potentially disruptive behavior?

An even more challenging dilemma arises when one of the parties says or does something in the mediation that has the unmistakable ring of bias, condescension, or disrespect. The mediator has a number of choices—the following are only a few of the options. First, s/he can decide to ignore the event for the time being, hoping that the negotiation will stay on track and perhaps revisiting the incident later with the parties separately or together. Second, s/he can intervene in the moment by calling attention to what s/he saw or heard, and either lodging his/her objection or inquiring about what the action or comment was intended to communicate. Third, s/he can inquire of the party who was the object of the action or comment, to find out what impact it may have had. Finally, the mediator can call for a break and discuss what occurred with each of the parties. None of these courses of action will be right for every case. And it is, of course, challenging to consider these options and others (and their respective advantages and disadvantages) in the split-second in which a timely decision must be made. To some extent, the mediator must use his/her intuition, and then be self-forgiving if the judgment proves to be unsound.

And what if the offensive remark is directed at the mediator?

The critical decision for the mediator is whether a response is needed for reasons related to the mediation itself. There are occasionally situations—particularly in joint sessions—where offensive, disrespectful, or bullying behavior directed toward the mediator must be addressed in order to foster a feeling of safety for the other participants in the mediation. Even in those situations, for example, there are choices to be made about how to address the offensive action of remark. For example, speaking separately to the offender might elicit an apology that could defuse the tension and possibly even create some positive momentum toward settlement.

Validating Differences and Commonalities

One of the key concepts in negotiation theory is that the parties' differences create opportunities for joint gains. In the classic example of dividing an orange, described in the book *Getting to Yes*, the fact that one child wanted to make juice and the other wanted only the rind for a cake created the opportunity for each to have the equivalent of a whole orange [53]. Culturally competent mediation means striking the balance between acknowledging and validating the parties' differences when they are relevant and at the same time looking for common ground.

How does this work in practice? A case in point: an elderly African-American janitor was suing his employer for race discrimination in terminating him. As the mediation began, the mediator asked if the parties were comfortable addressing each other on a first-name basis. The janitor said, "I prefer that you call me Mr. Jones." In the course of the mediation, he discussed his background as a sharecropper and the way that he was addressed as "boy" long into his adulthood. The central issue of the mediation thus became whether a settlement could be reached that did further strip this gentleman of his dignity. The fact that his life experience made him different from everyone else in the room could have been downplayed, but instead it was acknowledged by the mediator without condescension. The mediation resulted in Mr. Jones being reinstated in exchange for his withdrawing his suit, but the most memorable aspect of the mediation, he said, was that he was treated as an equal in the mediation room. That acknowledgment and reinstatement were worth more than a monetary settlement from Mr. Jones' standpoint.

A key element for the mediator is sensitivity to the following question: how does each person feel about his/her difference being acknowledged or treated as irrelevant? The answer to this question may be far from obvious, and the answer may change over time as the mediation unfolds. Taking breaks in the mediation for caucus sessions creates an opportunity to address such questions and thus keep the mediation on track.

Another key element for the mediator is recognizing that people have far more in common than often meets the eye. Identifying those common elements of the human condition can sometimes open the door to resolution. Among Maori tribes, the traditional method for resolving territorial conflicts between tribes was to gather for negotiation, which could only begin after the tribes have (a) discussed their lineage and the times in the past when their ancestors had helped each other; (b) named those in their respective tribes who had passed away; and then (c) shared a meal together [54]. Such elaborate rituals are ill-suited to modern mediation, but acknowledgment of common experience (e.g., the loss of loved ones) or the sharing of a meal can sometimes help to bridge gaps that initially might seem insurmountable.

Mediating Values-Based Conflict

Among the most profound differences that mediators encounter are those based on deeply held values—sometimes fueled by religious or political beliefs. For example, in the conflicts over abortion, advocates on both sides of the controversy are unlikely to find common ground, and neither believes that a compromise is morally acceptable [55]. Moreover, the values and beliefs that fuel this controversy are unlikely to yield to persuasion.

MIT Professor Lawrence Susskind has identified four methods for addressing values-based conflict: (a) focusing on interests and values separately (e.g., the parties might achieve a mutually beneficial détente without having to resolve their differences regarding values); (b) shift the goal of the mediation from resolution to dialogue, seeking to increase mutual understanding; (c) identify one or more overarching values on which the parties agree and that enable the parties to transcend the conflict; and (d) confront values directly with the goal of reconciling the differences [56].

In some cases, one or more of the parties may couch their differences as a matter of principle—for example, "I refuse to negotiate with a liar, as a matter of principle." In such situations, the parties do not disagree about values—both sides would readily agree that lying is blameworthy. Instead, the dispute is more accurately described as one in which one of the parties fears exploitation or is dug in because of anger over perceived exploitation in the past, or both.

Co-mediation as a Technique for Leveling the Playing Field

The parties in a mediation often wonder if the mediator can truly be impartial. This concern is heightened if, for example, the mediator is the same race, gender, or ethnicity as one of the parties but not the other. In divorce mediation with heterosexual couples, co-mediation—with one male and one female mediator—is often used. In a recent sexual harassment case, the female plaintiff asked the male mediator if he would be willing to have a woman co-mediator; the answer was yes, and the case quickly settled. Adding a co-mediator does not mean that a solo mediator could not be impartial. However, from the standpoint of feeling heard and understood, the parties' preference to have one of the mediators be someone with a background or characteristics similar to theirs makes sense and has proven to be a successful strategy for settlement in mediation. Co-mediation also adds value for the mediators. Drawing on the experience, skills, expertise, and perspectives of two people who have different approaches and have worked in different contexts will add to the diagnostic range and the variety of tools needed to handle complex conflicts. This is particularly true in situations involving diversity of race, culture, class, gender, and other characteristics.

The Power of Narrative

Discussing diversity issues in mediation, as in other settings, can be fraught with emotion. For those who have been subjected to discrimination, seeking to be understood on the subject of bias may arouse feelings of vulnerability. For those who have enjoyed the benefits of majority status, the same conversation may evoke feelings of defensiveness. These two reactions can feed each other, fostering a cycle of blame and denial.

In order to break that cycle, mediators have found that personal narrative can be a powerful tool for understanding. Narrative can overcome argument, because the teller is not seeking agreement—s/he simply recounts what happened and how the teller experienced that history.

Narrative is not a magic bullet. But in appropriate cases, it can unlock the door to resolution and understanding diversity.

One of the best case studies in the literature of mediation—mediator Carol Liebman's *Mediation as Parallel Seminars: Lessons from the Student Takeover of Columbia University's Hamilton Hall* [57]—tells a story of co-mediation. The students—primarily, but not exclusively, students of color—were demanding the creation of an Ethnic Studies Department at Columbia. Liebman, who teaches mediation at Columbia, was asked to mediate the conflict despite her position as a faculty member, but, because she is white, she sought out a minority co-mediator, political scientist Carlton Long, and the two of them successfully mediated the conflict.

One of the valuable insights from Liebman's account of the mediation is the metaphor of parallel seminars, which captures three important aspects of the case. First, the idea that mediation involves education, not only for the mediator, who is learning about the dispute, but also for the parties, who may be unfamiliar with the process of mediation and interest-based negotiation. Second, the idea that these seminars can take place separately—in parallel—when the tensions between the parties, as in this case, run so high that the parties are unwilling, for the most part, to participate in joint sessions. Finally, the idea that in situations where diversity issues are present, there is yet another important layer of learning that is underway, as the mediators and the parties try to understand the identity-based and value-based issues that are driving the conflict.

Because we can never entirely walk in each other's shoes, diversity issues require of mediators an ongoing openness to learning and a commitment to bringing "beginner's mind" into every mediation. Even when diversity issues are not present, the idea of the parties and mediator educating each other is a valuable model for the mediation process [58]. In the mental health professions, this aspect of the process might be referred to as psychoeducation.

Welcoming Diverse Practitioners to the Field of Mediation

Attend almost any conference of mediators in the United States, and you might wonder: where are the people of color? [59] For reasons described in this chapter, mediation can be more effective in resolving conflict if the ranks of mediators reflect the diversity of our society.

There appear to be at least three reasons for the underrepresentation of minorities in the mediation field. First, minorities are underrepresented in the occupations from which many mediators—perhaps even a majority—come. The following census figures for 2017 tell that story, which has improved a bit, but only a bit, in recent years (Table 3.2) [60]:

Table 3.2 Underrepresentation of minorities in selected professions

	US population (%)	Lawyers (%)	Psychologists (%)
African-American	12.1	5.6	6.5
Asian	6.2	4.4	3.6
Hispanic	16.9	4.8	8.5

Subtle, and not so subtle, headwinds retard progress of non-whites in these professions. It was not until 1943, for example, that non-white lawyers were even allowed to join the American Bar Association.

Second, mediation is still a relatively new phenomenon. Making a living as a mediator can be extraordinarily difficult. In minority communities in the United States, the individuals who achieve the level of education required for work as a professional may be among the first in their families to do so. The risk—both social and economic—involved in using that education on a relatively unconventional occupation can be a formidable obstacle.

Finally, the lack of minority participation in mediation can become a self-fulfilling prophecy, as the field of mediation looks less appealing to would-be minority mediators until there is a critical mass of people of similar background.

For all of these reasons, it is incumbent upon those who seek to advance the use of mediation broadly throughout the United States to take affirmative steps to invite and include minority mediators.

Conclusion

Becoming a culturally competent mediator is a process, not a destination. The complexity of the task of mediation is multiplied severalfold by the diversity of people that mediators encounter. Cultural competence requires a form of learning that is not only intellectual but also lodged in the heart. Compassion and empathy are as vital as curiosity and an open mind.

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Providing Medical Care to Diverse Populations

4

Deborah Washington and Robert Doyle

If we are to achieve a richer culture, richer in contrasting values, we must recognize the full gamut of human potentialities.

(Margaret Mead)

Introduction

It is not yet evident how strong of an influence diversity holds on clinical decision-making or quality of care. What remains unclear is the manner in which disparate patient characteristics function. The associated cognitive procedures are complex. Affordable care, access to care, and compliance with recommended treatment are examples of factors that influence health outcomes, but fail to provide a definitive explanation for variations that deviate from the norm. Explanations for these differences are lacking. The capacity for race and ethnicity to influence treatment and resource allocations, for example, is a decision process open to interpretation. This is problematic because the ability to evaluate a clinical decision requires understanding the many interrelated elements that contribute to judgment. In the end, there exists the need to evaluate clinical choices and to understand the extent to which patient attributes have the power to influence those determinations. This chapter will tackle the challenge of what it means to provide culturally sensitive healthcare to arguably the most diverse population on the planet. Although the information provided is focused on the healthcare environment, the concepts discussed are relevant to educators, diversity trainers, and professionals from other social sciences.

Background

The demographic shift of the American population from majority White to majority-minority is fast approaching. The boomer generation is majority White, and those younger than 35 are predominantly ethnic minorities [1]. The cultural and linguistic profile of the immigrant population as of 2016 shows a non-European entrance into the country. The Migration Policy Institute reports that while most people under 5 years old living in the United States describe speaking only English at home (78%), the rest of the population speaks Spanish, Chinese, Tagalog, Vietnamese, Arabic, or French [2]. More than half of the immigrant population has private healthcare coverage, and approximately 30% has public health insurance. Immigrants and refugees face stress-related mental health issues linked to their life situation, the need to acculturate to US culture, encounters with discrimination, and experiences with trauma [3]. Economic hardship and loss of status complicate the process of settling into an expatriate life.

Greenberg [3] outlined barriers to accessing mental health services for the immigrant population. They include:

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- Differences in symptom expression, understanding etiology and effective coping mechanisms
- Stigma of mental illness
- Language barriers and lack of interpreters
- Patient-provider cultural concordance
- Fear and mistrust of the healthcare system

As the United States goes through a ground swell of change in healthcare delivery, one fact remains unchanged: the population of patients treated will be more diverse. The country known as the melting pot of the world grew to its current status as a world leader due to the influx of new notions and confluence of diverse cultures that challenged the status quo and pushed the envelope of possibility. Whether we talk about a jazz funeral stepping to the beat of Louis Armstrong's syncopated rhythms or Neil Armstrong's "One small step," no one doubts that America placed an indelible imprint on the modern world. Although America met President Kennedy's challenge to land a man on the moon and return him safely to earth, decades later we still struggle to understand the man or woman standing next to us on terra firma. If one considers the number of cultures and subcultures that coexist in America, the complex calculations to go to the moon and back might seem relatively easy math compared to the many permutations of culture in our society.

This acknowledgment becomes increasingly important within the context of the national dialogue on health disparities and unequal treatment. The 2002 Institute of Medicine (IOM) report entitled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, repudiated the assumption that the American health delivery system was fair and equitable. A cornucopia of questions related to quality of care and access to care for groups on the social margins followed the groundbreaking study in quick succession. The synthesis of research exemplified by the report moved race and ethnicity into the forefront as important variables in the discourse on health outcomes for Americans. These variables symbolized conspicuous inconsistencies in the quality of health services that differed by ethnic group for people living in the United States. The channels of service to persons on the edges of society, compared to those available to the dominant social group, did not reflect parity. But who can possibly be an expert on so many diverse cultures that converge in waiting rooms across this country 24 h a day?

Health Disparities

The existence of inequitable treatment provided to patients with dissimilar sociodemographic details is one of the great ethical and analytic challenges in modern healthcare. Present-day research is a helpful means for sharing current thinking on variations in health status and the outcomes of health management as they relate specifically to ethnic populations. Contributing factors highlighted in the literature are socioeconomic realities, flawed systems, or inadequate training in cultural competency. Relevant to the last contributing factor of cultural competence, English proficiency, socioeconomic status, gender, sexual orientation, cognitive or physical ability, and religious or spiritual belief systems are inherently neutral social classifications that take on added dimension when linked with stigmatized or marginalized social groups. English proficiency and Hispanics, socioeconomic status and Blacks, or religion and Muslims are life characteristics that may be variables or proxies for yet another unidentified process when examining the intricacies of disparities in healthcare.

One of the most challenging possibilities is that health outcomes for diverse groups are impaired by bias in clinical decision-making. The integration of stereotypes, for example, into the information schema that health professionals maintain about minority patients raises questions that healthcare researchers can evaluate and understand. The implications for the provider and the patient are basic and fundamental: perfunctory or inadequate care must be avoided, because the presence of bias leads to moral and legal imperatives.

Nonclinical factors such as race may not consistently demonstrate the presence of bias. Socioeconomic status, for example, as an influence on decision-making, may also result in debatable recommendation for treatment [4, 5]. Diagnostic failures linked to errors in judgment can stem from automatic thinking compared to a more consciously critical or analytic approach [6]. Stereotypes are a form of automatic thinking leading to assumptions and a faulty foundation for action.

Intersectionality

Most definitions of diversity include a broad-based description of the concept taking into consideration that different dimensions of social location are not mutually exclusive in understanding impact. Race, gender, and age, for example, are interconnected aspects of selfhood. These interdependent characteristics influence personal encounters, and their state of co-occurrence is known as intersectionality:

> Intersectionality is a way of understanding and analyzing complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are shaped
> by many factors in diverse and mutually influencing
> ways. When it comes to social inequality, people's lives
> and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but
> by many axes that work together and influence each other [7].

Intersectionality brings a more holistic view to understanding the dimensions of othering [8]. The importance of the construct to a healthcare paradigm embraces the idea that response to some aspect of identity based on flawed perceptions has import for the patient experience of care. The middle class, boomer, male, heterosexual, White provider may have a stressed encounter with a homeless, Black, transgender, millennial.

Cognitive Dissonance

Cognitive dissonance may provide insight into the lack of awareness that allows for discriminatory behavior. Red flags typically do not go up when socially undesirable reactions become part of interethnic encounters in which prejudice is called into question. Cognitive dissonance describes the mental reframing of a given situation that decreases the level of discomfort that might warn of the presence or employment of objectionable reactions. Rationalizations and justifications are utilized. These protective systems of self-esteem allow for differing perspectives on communication and behavioral missteps that breach effective patient engagement in a cross-cultural encounter.

Cultural Sensitivity and Clinical Practice

In a 2004 position paper, the American College of Physicians encouraged provider awareness of personal bias and stereotypes as an important course of action needed to understand the degree to which these factors could influence healthcare decisions. As a case in point, DelVecchio et al. [9] described the so-called medical gaze that results from professional training. This expression suggests the manner in which the clinician organizes information that pertains to a specific patient.

Of course, no clinician can be an expert on every culture of varied patients they treat. Every clinician, however, can gain insight and a degree of expertise about the culture of each patient by following a few simple guidelines.

First, culture needs to be defined. Even though the dictionary gives several definitions of culture, the ones relevant to this chapter include (a) the beliefs, customs, practices, and social behavior of a particular nation or group of people; (b) a group of people whose shared beliefs and practices identify the particular place, class, or time to which they belong; and (c) a particular set of attitudes that characterizes a group of people. Simply stated, culture describes the beliefs, behaviors, and values held collectively within a group, organization, region, or nation.

Including the information about a patient's cultural background makes sense in contemporary clinical practice for several reasons. Clinical decisions must have exacting quality and bear scrutiny. High decision quality is an important goal and the ultimate example of good patient care [10]. Applying this information in a practical and workable way is a worthy goal. The process of making a decision is a particular example of information utilization, and illustrative mental models of population groups can be effective aids in care delivery. These cognitive models can be complex in design and result from processing extensive information—what is seen, read, and experienced must be accurately applied for effective care of the individual.

On an individual level, each patient presents as a product of several cultures, and each of these cultures influences the individual's beliefs about the way the world works and the way people should interact. Various cultural imprints determine a patient's behaviors, including social gestures, use of eye contact, facial expressions, manner of dress, and rituals for greeting. The patient's values, such as the importance of family life, career, religion, and social responsibility, all derive from some interplay of cultures in that individual's life trajectory.

As this textbook goes to press, Barack Obama is serving his second term as president. Divested of his role as leader of the country and using him as a model of a cultural being, how would a clinician meet the challenge of incorporating Mr. Obama's well-known cultural background into an understanding of who he is as a person? This is a complicated question from a clinical perspective. The president self-identifies as African American; however, this over simplifies his rich cultural heritage. *African* American may fit the president better than most that choose this cultural identity given his father is of African heritage and his mother was born in America. For the majority of African Americans, many generations separate them from the nearest relative of African ancestry. On the other hand, Mr. Obama knew his father's precise birthplace and the customs and religion of his relatives. Many of his close relatives, including a half brother, still live in Africa. The actual impact on personal identity and worldview of this cultural connection as it compares to other African Americans is an interesting point for discussion. For example, Mr. Obama spent much of his younger years living primarily with his White mother and grandmother. Even more pointedly, how similar was his boyhood in Hawaii to that of an African American boy growing up in Harlem? How was his experience at Harvard University like that of a young Black man attending Howard University? From the model of African American as a generic cultural designation, in what manner is any of this a pertinent context for the aspiring culturally sensitive clinician? How might any of this contribute to understanding the person receiving medical care or treatment?

Teaching Implications of Race and Ethnicity

Race and ethnicity have gained attention as important to understanding healthcare quality; more specifically, the influence of these factors on defining excellence in patient care is increasingly apparent. The significance of ethnic identity to assessment, care, and discharge planning are evident, and these domains of practice hold implication for the clinician-patient relationship as a function of clinical decision-making. Knowledge of the group as it relates to those who are culturally different often supersedes the customary value for the uniqueness of each individual.

The movement to describe and educate healthcare providers about cultural sensitivity and its inclusion in individual practice brings into closer range the issues raised by health disparities. Culturally competent care, cultural sensitivity, and culturally and linguistically appropriate care are examples of terminology that indicate a change in medical and nursing perspectives on health management and education. This nomenclature is comparative, and it orients clinical practice and principles of care to the unique end users of health services according to the cultural identity of patients, their families, and the communities in which they live. The consumer becomes the focus of the healthcare experience within this paradigm, while the resulting notion of equal treatment underscores the importance of consistency in action, intention, and effect as essential qualities of good clinical practice. To a notable extent, such care is assumed impervious to inexplicable variation. For example, a Black physician, who attended Harvard Medical School, might find less common cultural ground with President Obama than might be assumed. Ethnicity as a basis for short cuts to understanding others can cause problems in the clinical relationship. On the other hand, becoming a cultural anthropologist for each patient from a different cultural background is untenable. Clinical tools are needed to gather information important to the context of care that is intended using the concept of cultural sensitivity. Such tools are nuanced with the social history of cultural groups.

Rawls [11] explored the difference between Black and White conversational codes of conduct. In a social environment, initial ingroup conversational encounters are managed differently: for Whites, introductory dialogue is focused on information gathering, and social credentials (occupation, place of residence, education) are established at the beginning; for Blacks, introductory talk separates into what is judged public or private in addition to nonhierarchical communication as the basis for relationship. Information itself is important to Whites, “White Americans prefer to build their conversations only after the production of categories” (p. 249). When the aforementioned processes do not occur, making sense of the interactions becomes problematic, and from a Black perspective, category questions require motive, i.e., the social history of the group creates guardedness. Caution is culturally prudent as it relates to type and amount of information shared.

An example of wariness relevant to healthcare is the quality and effectiveness of the contemporary clinical interview. The current interest in cultural sensitivity aids in understanding why African Americans are circumspect in their answers to certain questions. This tendency is relevant because clinical outcomes are dependent on analytic data as well as the best discretionary information collected from the patient.

The authors have created a series of rhetorical questions to help clinicians reflect on their own diversity. See Exercise 1 below:

Exercise 1
What is your cultural identity?

What is your race? Is this how you self-identify most of the time?

What is your gender? Is this also your gender expression?

What is your religion or spiritual tradition?

What is your ethnic heritage? In what way are you connected with its customs, beliefs, values?

What is your sexual orientation? What is the impact of culture/ethnic identity?

What is your socioeconomic status? Is it based in family support or autonomous living?

What is your political point of view and how is it informed by any aspect of your identity?

The longer the list of questions, the more obvious cultural diversity becomes. A self-examination based on this interview tool provides an awareness of personal identity. Most clinicians have never taken the time to think about the nuances of their own cultural diversity, so one would not be surprised that the average clinician likely knows even less about the patient’s cultural complexities. Once a comprehensive understanding and appreciation of the patient’s cultural background is established, the clinician can sidestep suppositions or stereotypes based on a single aspect of identity.

The term cultural diversity extends the notion to encompass ethnic variety, as well as socioeconomic and gender variety, in a group, society, or institution. Although ethnic, socioeconomic, and gender variety cover some of the cultural diversity encountered in patient populations, cultural diversity manifests in many other forms.

In Patient Care Services at Massachusetts General Hospital (MGH), there are seven pillars that define the populations of interest covered by a curriculum on cultural sensitivity and diversity. These are race/ethnicity, age, gender, socioeconomic status, sexual orientation, religion/spirituality, and physical/cognitive ability. These population groups have a social history that locates their position as the marginalized or vulnerable in the terminology used in the discourse on unequal treatment and disparities.

Consider that an ethnic minority patient may view her or his cultural background differently than may be assumed by a nonminority clinician. For instance, Dr. Jones learns that his new patient, Jian X., grew up in China. He assumes that she prefers traditional Chinese medicine interventions and refers her to the new Alternative Therapies Clinic for acupuncture to treat her carpal tunnel syndrome. Dr. Jones feels a sense of satisfaction with the referral to a new hospital service established to support and serve a diverse population. Jian, however, is disappointed that Dr. Jones did not simply prescribe a pill to relieve the pain and inflammation. In China, questioning a doctor's authority equates to disrespect, therefore Jian does not consider asking for an alternative to the prescribed therapy. If he knew Jian better, Dr. Jones would have understood that Jian identifies herself first as an engineer, second as a woman, and third as a Chinese immigrant. As a structural engineer, she makes decisions based on math and science. Jian would have welcomed a discussion about the evidenced-based advantages of one anti-inflammatory medication over another, but she reticently accepted the treatment Dr. Jones prescribed based on his well-intentioned assumption about her. Her firm relies on Jian to meet a deadline on a major project, so she needs relief as quickly as possible. Her dilemma includes scheduling an appointment with acupuncturist in 3 days or taking a prescription that might offer relief in a matter of minutes or hours. The cultural context for Jian's problem illustrates the need for clinicians like Dr. Jones to take a culturally sensitive approach based on actually understanding the patient's needs rather than assuming they do.

Clinicians are more likely to approach the challenges of care for a multiethnic and multilingual population more effectively, if cultural knowledge and resources commensurate with needs are available to them. These newly identified demands of good care require updated responses. Knowledge reflecting the domains of perception, memory, and judgment endemic to the individual practitioner moves new questions to the forefront of healthcare and disparities research. If scientific inquiry is to be thorough, there is an unavoidable question in the search for answers to health disparities. What if differential treatment is the result of ethnic bias by the healthcare provider?

Ethnic Bias in Clinical Decision-Making

In answer to the concern about a level of competence in clinical practice as well as quality and safety in care delivery to the increasing dominance of a multicultural society in the United States, a course of action to address these issues became a part of the national healthcare debate.

In 2004, the Agency for Healthcare Research and Quality (AHRQ) and the Office of Minority Health (OMH) established a research agenda to identify the components of cultural competence. From an organizational perspective, the effectiveness of this approach began to appear in the literature Betancourt et al. [12]. Nursing models that captured concepts such as expertise, skill development, knowledge, and awareness gained attention Campinha-Bacote [13]. Such efforts addressed issues of mixed performance in health outcomes evidenced in the literature comparing population groups, and it has been possible to audit research and produce studies demonstrating care below par based on ethnic background. However, there is not enough complied evidence to give legitimacy to the claim of ethnic bias in clinical decision-making such that the process can objectively test positive for its presence.

Figure 4.1 is a conceptual model of proposed influences on clinical decision-making as it relates to unfamiliar ethnic minority culture. It is a conceptualization by the authors of the decision maker who does not choose the prevailing treatment for an ethnic minority patient. Although the choice may remain clinically defensible, the alternative may not hold the same standing as the more prevalent treatment option. In such a scenario, the cognitive construct of the patient held by the decision maker is open to interpretation.

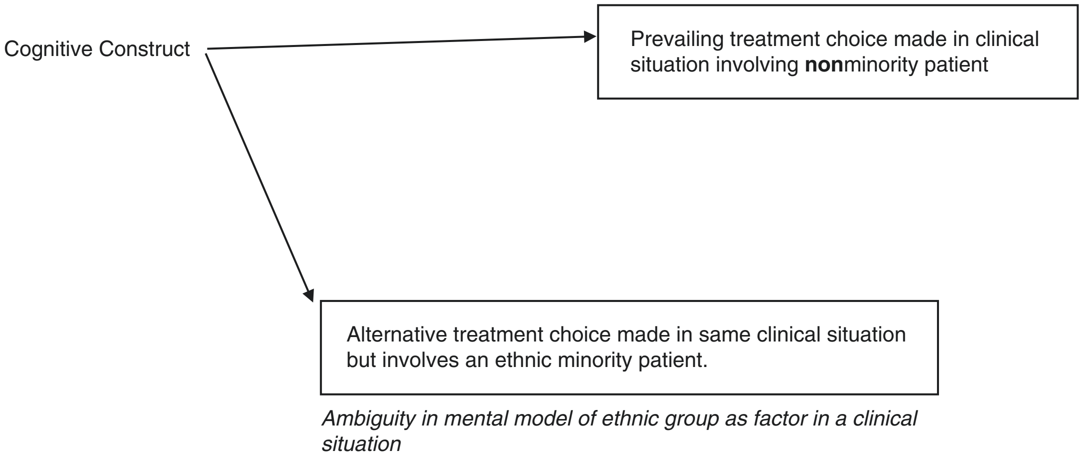

Fig. 4.1 Treatment dichotomy: cognitive construct for treatment decisions involving the ethnic minority patient

Identity Theory

Identification is the idea that persons perceive themselves as having a social as well as a personal identity. Social identity connects the individual with those considered “the same.” The identity (social or individual) that dominates is situational, however, and theory suggests social comparison as a third aspect of the dynamic superimposed on the dyad of identity concepts. This specific instance incorporates the perspective that each individual also seeks an evaluation of self in comparison to those who are similar.

Social identity theory dates from 1979 as developed by social psychologist Tajfel, who studied intergroup relations. Theoretical concepts included the interaction between personal identity and social identity Brown and Capozza [14]. Tajfel suggested that group assignment creates a situation in which individuals construct a positive sense of self, based on group inclusion. An ingroup and out-group awareness is associated with embracing a group identity constructed from characteristics considered common among those who comprise the group. It is unclear if these attributes are generally viewed as diagnostic of group membership or merely symbolic.

A group trait idiosyncratic to a shared identity is a complex construct. It is a difficult supposition to ascertain among large numbers of disparate individuals. Nevertheless, popular culture allows for such familiar generalizations about social groups. These abstract properties are well known, but conspicuously undesirable as descriptors, because using them served to marginalize. African Americans, for instance, have a unique American history in relation to social inequities, but despite a context of racism and discrimination, Black people forged a cogent cultural and group identity. Within the characteristics of this distinctiveness, a fuller understanding of the relationship between cultural coherence, health status, and clinical decision-making may emerge. By what means ethnic or cultural identity functions, as a factor in healthcare decisions, remains unexplained.

The theoretical tenets of social identity theory and related scholarly perspectives on the principles of group membership do not nullify the concept of a self-determining personal identity. While individual perceptions and feelings can be affected by the ideas and opinions of others, it can also be assumed that each person within the group remains an autonomous thinker. This premise suggests the elements of a stereotype may be pliable to personal frames of reference in addition to models disseminated by the dominant social group.

The fluidity between the dominance of social identity or personal identity is a question of situational demands. There is the implication that trait consistent factors exist, and together constitute identity categories. It is conceivable within the context of this reasoning that the individual incorporation of a category means enfolding stylized traits that are consistent and recognizable to the individual member of a group, the associated principal group, and to the general social order.

Exercise 2
Consider your responses to Exercise 1 then rank them in the order that you feel best describes your core identity. Jian ranked her profession as the most important part of her identity followed by her gender then her immigrant status. Which aspect of personal identity holds priority in your self-concept? Which part of your individual cultural identity comes in second, third, and so forth? Did some aspects of your unique cultural identity seem more difficult to rank than others? What aspect of your cultural fingerprint drives your decision process? Patients may make medical decisions based on their unique cultural priorities, so we as clinicians should be mindful of this.

Teal and Street have proposed four elements for culturally competent communication in the medical encounter [15]. They list communication repertoire, situational awareness, adaptability, and knowledge about core cultural issues [15]. Betancourt and colleagues noted that cultural differences between physician and patient may place barriers to effective communication, which translates to patient dissatisfaction, poor adherence to treatment plans, and adverse health outcomes [16]. Others point to improved health outcomes with patient-centered communication [17, 18]. Moreover, a culturally sensitive clinician should be able to realize and respond to the sociocultural differences between physician and patient [19]. While patient-centered care provides for improved care for all individual patients, culturally competent care emphasizes appropriate and equitable distribution of care in patients from diverse and disadvantaged backgrounds [20]. We posit that patient-centered care enhances culturally sensitive care and lies at its core. Without a patient-centered approach, those patients who present from outside the mainstream parts of our society will feel marginalized and likely not return to treatment unless emergency situations force them to come back.

Communication: Reading Between the Lines

Let us look at each facet of culturally competent communications in the medical encounter as described by Teal and Street. First, the clinician must possess a communication repertoire. The clinician's communication repertoire multiplies the effectiveness of sensitive interaction between the caregiver and the patient. According to Shapiro, a culturally competent communication repertoire includes basic attitudes of empathy, caring, and respect that form the foundation of all clinical encounters [21–24]. Fundamental communication skills build upon active listening, acknowledging sociocultural aspects of illness, inviting patient perspectives, inquiring about socioeconomic implications of treatment, and empowering patients to make decisions [25–27]. The goal of effective communication in any clinical encounter is twofold: obtaining accurate information from the patient and providing the pertinent information that the patient needs to make decisions about treatment.

Learning tradition dictates that initial clinical evaluations are organized in a standard format starting with a chief complaint then moving to the history of present illness followed by medical history, family history, and social history. Those who work with children and adolescents place special emphasis on a developmental history. All clinicians, however, should consider including a cultural history in every initial evaluation. Some clinicians delegate the cultural information about the patient to the social history, and this usually suffices, if the patient comes from a similar cultural background as the clinician. However, adding a separate cultural history for any patient coming from a different background than the clinician, or one not represented by mainstream culture, is beneficial. The cultural history serves as a valuable source of information for anyone who reads the patient's chart. Moreover, this type of documentation should be viewed as a process instead of simply part of the initial evaluation.

Think of a cultural history as an evolving process. It begins with the initial evaluation and continues to grow with each subsequent encounter.

Of course, the clinician-patient relationship will need nurturing. Sometimes, a gradual accumulation of cultural information is the most effective and efficient approach to gather information. Consider the case of Mr. M., a Mexican migrant fruit picker in California's central valley. His "green card" expired several months ago, but his poor English prevented him from finding the appropriate authorities to renew his worker visa status. Unfortunately, Mr. M. found himself in the emergency room after he accidentally gashed his left hand due to a slip of the pruning knife. As the young resident tried to establish rapport by learning about the patient's cultural background through the use of an interpreter, Mr. M. became visibly anxious. The resident persevered with further questions, such as: How long have you been in the United States? Where did you live in Mexico? Do you have other family members living with you here? The resident intended for the questions to establish a connection and rapport, but they worked in the opposite direction. Mr. M. feared that the clinician wanted this information to pass it along to the immigration authorities. After the resident finished suturing the wound and giving Mr. M. instructions for after-care, she asked him to return in a week for suture removal. Mr. M. smiled and nervously thanked her. He, however, dared not return to the hospital, since he thought immigration officials would be waiting to deport him.

In retrospect, the resident could have chosen less threatening questions or simply deferred these types of questions until she gained his trust. She did not know about her patient's visa status, and that can be forgiven. However, she missed the escalating anxiety Mr. M. exhibited and she did not adjust her approach. Teal and Street refer to this ability to perceive and attend to the nuances in the patient's behavior as situational awareness.

Awareness: Keeping an Eye on the Compass

Situational awareness along with self-awareness comprises the second of the four critical elements in culturally competent communication [15]. Sometimes subtle, such behavioral changes usually signal a problem or misunderstanding in the patient-clinician relationship. The patient may perceive race base cues from the clinician during the encounter. Maintaining self-awareness related to bias, prejudice, micro-aggressions, and cultural miscues can influence body language and interpersonal reactions that can derail the clinical encounter. According to Epstein and Street, situational and self-awareness enhance communication to clear up confusion, deal with disagreements, and come to a common understanding of the medical problem and the preferred treatment options [17]. Situational and self-awareness result from "mindfulness" in the medical encounter. The term "mindfulness" refers to a new form of psychotherapy based on cognitive behavioral therapy that draws upon Eastern meditative techniques [28, 29]. In essence, mindfulness allows the clinician to fully focus on the patient in the present moment.

Conversely, the role of race-ethnicity in a mental model is provocative. As a social construct, its connotation is not typically positive. Placing race-ethnicity in the data set of information available to a decision maker is nettlesome since it evokes unsettling historical matters and causes doubt and uncertainty about contemporary ones. It is also difficult to concede that in any given situation, race-ethnicity is insensible to another. To say the concept does not register negatively is not to say it has no register. The manner in which it correlates as data in a decision schema is presently undefined; consequently, the probability that the concept indicates a point of uncertainty or ambiguity in the decision process by its simple existence is worthy of consideration. If the race-ethnicity construct is included as a variable, it is a reasonable expectation that its use is credible. In other words, it is important to understand whether race-ethnicity indicates a narrowly defined group, or whether it more appropriately serves as a parenthetical determining factor within the context of other issues. Stereotypes associated with race-ethnicity are sometimes a proxy for a combination of qualities belonging to a person. On the other hand, it may be imposed on characteristics outside personality. More specifically, is race-ethnicity irreducible and not able to be further divided or simplified into component parts?

In mindfulness groups, one of the more memorable exercises involves eating a piece of chocolate. Each member of the group receives a single candy as a group leader guides the participants through a full appreciation of that one piece of chocolate. The leader instructs the group to savor the aroma then relish the texture and color. Over the course of several minutes, group members experience every detail of the small treat before they taste it. Most people have never focused on a piece of chocolate so intensely, so they never fully appreciated the essence of chocolate. Unfortunately, the time-pressures of managed care rarely allow clinicians to savor complex cultural diversity that each patient brings to the encounter. Physicians and other practitioners rush to obtain diagnostic information with the goal of a quick and efficient move to treatment. Like someone who mindlessly gobbles a piece of chocolate barely tasting or enjoying the experience, clinicians miss out on the cultural flavors that make clinical encounters so rich. The pressures of acuity and third party payers drive interactions to the contemporary care environment.

Imagine, instead, a mindfulness approach to each patient encounter. In this scenario, each clinician becomes a discerning expert on patients from very diverse background. Once she or he adopts the mindfulness mindset, that clinician can appreciate the unique ways that a person's race, religion, ethnic background, sexual orientation, gender and/or age, come together as the richly textured cultural identity of a patient. The interface between race, religion, ethnic origin, sexual orientation, gender, age, and a number of other elements produce cultural identity as it is currently understood. The patient and the clinician may not be culturally congruent, but this offers opportunity for the professional and personal growth, especially for clinicians who wish to understand the variety of human experience that diversity offers.

Ethnocentrism

Ethnocentrism—or the perspective that the culture of the ingroup is the definition of normal—serves as the boundary marker for a group that dominates. For example, *historically European* and *biomedical* are labels for what is familiar and approved in the operating standards accepted by the American healthcare system. This is especially true in meeting the requirements of the marketplace (e.g., care costs, funded research) as an influence on care delivery. However, this viewpoint may have run its course with the latest census, because the dominant group has reached a tipping point with the mass arrival of non-European populations [30]. Ethnocentrism was once the prototypical model of care delivery, since the demographics of the United States reflected the European roots of the nation. What holds the attention is the international sources of these new demographics flow from countries customarily treated as lacking in global value or importance (e.g., third world countries, war torn countries, developing countries). Upon residence in the United States, census designations force adoption of checklist identities culturally informed by the American experience. More specifically, African becomes Black and Mexican becomes Hispanic, and the consequence of this is that different immigrant groups now dominate communities that are the focus of a contemporary public health agenda. In Massachusetts, for example, the gain in state population for the last census was dependent on immigration. New immigrants arrived to the state from South and Central America, India, China, Russia, Vietnam, and the Caribbean [31]. Ethnicity and health disparities are two typically correlated variables.

The characteristics associated with ethnic identity have the potential to inform a more comprehensive understanding of a group's social identity. The latter involves the larger concepts of categorization (Black, Muslim, southerner), identification (ingroup, out-group), and social comparison. Ethnic identity with its cluster of descriptive features (race, religion, language, history, etc.) has the capacity to more precisely outline the features that constitute a social identity.

Once the link between social identity and ethnic identity has been established, it becomes possible to explore the interpersonal and intergroup relationships that are often problematic in the clinical setting.

Ethnocentrism is often cited as an example of an ingroup perspective [32], and attached to these categories are value judgments [33], because the ingroup designation creates boundaries and conscious articulation of differences motivated by comparisons. The anticipated outcome from such processes is a positive sense of self-worth stemming from group inclusion. The notion that social identity is created by its designate and adopted freely by them is incorrect, since it mistakes social identity for group identity. Prejudice and stereotypes by the social identity designators make this proposition questionable. To the contrary, these negative influences are often the impetus to disestablish a social identity and when the creation of a group-based identity is the outgrowth of a circumscribed social existence the results demonstrate a high degree of refinement [34, 35]. This cultivation is typically given disproportionate meaning outside the social structure of the relevant group. An emblematic illustration is the way African American frankness is misconstrued. Outside its cultural paradigm, it may seem to be brusque or socially incorrect behavior.

Negative Social Frames

The difference between the patient's and the clinician's cultural identities can lead to inaccuracies in communication. Sometimes a language barrier exists between the patient and the clinician. Interpreters can be invaluable in such situations. A contemporary subtext to this focus is the issue of citizenship. Since the 1970s there has been a decrease in European immigration to the United States. An increase in the numbers of people coming into the country from Latin America and Asia replaced this reduction. This new influx of people created concern in the native-born population about the potential loss of a core American identity Grant Makers Health [36]. A perceived state of perpetual foreignness of some populations is a source of resentment that targets immigrants as largely illegal, poor, and heavy consumers of tax dollars. Such stereotypes of ethnic groups may contribute to unequal treatment in care. Ethnocentrism was once the prototypical model of care delivery as mentioned earlier.

Today, technology allows for small or remote facilities to connect with interpreter services via electronic audio or audiovisual conferencing devices. An interpreter often provides cultural insights. Nevertheless, specific skills are needed to work effectively with this valuable resource. For example, the clinician should observe the patient while the interpreter asks questions in the patient's native language or receives information in the other language. It is instinctive to look at the person speaking, i.e., the interpreter; however, the focus of an interpreter-facilitated clinical interaction remains connecting with the patient and not the interpreter. Attention to the patient allows for observation of the patient reaction to questions and any discomfort associated with the answers. A mindfulness approach applies in this case even with major language barriers between the clinician and patient.

At other times, an accent, medical jargon, or idiomatic expression can lead to misunderstandings. The clinician must observe the patient closely to discern whether any change in body language or facial expression signals a problem. Using situational awareness and self-awareness permits clinicians to remain mindful in the moment with their patients and prevents miscommunication in sharing information and arriving at an appropriate treatment plan acceptable to the patient.

In a mindfulness-based patient encounter, the clinician must pay attention to her/his own cultural identity and beliefs while realizing the stereotypes and prejudices she or he might hold about persons from the patient's demographic group [29]. This, however, comprises only a fraction of the equation: self-awareness. A mindfulness-oriented clinician also must assess the patient's spoken and unspoken reactions to her or his behaviors: situational awareness. The patient's reactions may manifest as changes in facial expressions, shift in posture, choice of words, tone of voice, or even an awkward silence. Although this sounds like sound advice for any patient interaction, clinicians should show particular vigilance for these signals whenever they meet with patients from cultures quite different from their own.

Discomfort with ethnic bias as a factor in clinical decision-making is related to uncertainty about the existence of the antipathy usually associated with race prejudice (Hobson 2001) [37]. Inveterate dislike as opposed to a random, negative reaction based on a real time event challenges the traditional image of the egalitarian and objective clinician. This latter depiction is the more customary portrayal of the health professional and is not usually part of public dispute. Nevertheless, the experience of African Americans with the healthcare system is sometimes pictured differently. A 1999 special report supported by Seattle Public Health explored the experience of 51 African American patients through an interview project. Those questioned related incidents in which they described differential treatment, and many occurrences included a "perceived negative attitude" from healthcare professionals further detailed as behavior that was "rude," "cold," "inattentive," and "belittling." "The perceived negative attitude exhibited by health care providers or their staff members were not reported as hostile but as uncaring or rude behavior" (p. ix). The respondents were patients from approximately 30 different health centers and recalled experiences as early as 10 months previous to the interview. Types of perceived discrimination captured by the report were: differential treatment, perceived negative attitude, treated as dumb, made to wait, ignored, pain ignored, inflicted unnecessary pain, racial slur, harassed, being watched, and health personnel exhibited fear (Hobson 2001) [37].

While the Hobson study outlined examples of behaviors identified as discriminatory by the respondents, it was not the purpose of the study to examine another unexplored phenomenon within its chosen scenario. More specifically, the responding behavior from the study subjects to the actions and manner of the clinicians was not part of the inquiry, so the interplay between patient and provider is raw material for further research. With reciprocal feelings as context for the clinical encounter, it is reasonable to surmise a type of relationship not subject to control of the will. In the contemporary healthcare system, it is becoming less and less likely that patient and provider have more than a sporadic and incidental relationship, and they are very often not known to one another. Expanding the premise further includes acknowledgment that development of expertise is based on accumulated knowledge of the typical patient. This emblematic patient becomes a point of comparison and is affectively representative for each clinician of what is reasonable or excessive, characteristic or embellished. The emotional reaction of the Hobson [37] study (Hobson 2001) subjects and their responding behavior poses an interesting scenario of stimulus and response between patient and provider. In particular, Rosenthal [38] posits that when the provider is interacting with an out-group member stereotypically viewed as "loud, hostile, lazy, criminal and low intelligence" (p. 132).

Rosenthal [38] either as the one patient of the day or the tenth from the specified ethnic group, the effect on care deserves inquiry. With feelings as context for the clinical encounter, there is sound basis to surmise the possibility of a strained and unacknowledged tension in a cross-cultural interaction. While it may be true that not all clinical encounters involve the activation of ethnic bias, the resulting hypothesis exploring the kinds of data that increase or decrease the presence of bias, prejudice and discrimination in thought and practice becomes a worthy goal. Rosenthal [38] goes further "Research can shed light on the way racial biases are activated and how they persist, fostering the development of empirically validated strategies to neutralize the effects of these stereotypes" (p. 139).

Bodenhausen et al. [39] did the work of investigating the influence of affect on perception and behavior between ingroup and out-group members. In their writing, the authors acknowledge "psychologists have known that, through experience, certain stimuli come to elicit consistent affective reactions" (p. 321). The barrage of social messages about ethnic groups has not abated with the passage of time, and in the absence of censure, the amount of such information absorbed by any individual is open to conjecture. Whenever there is no social contact to contravene about the information communicated, the patient becomes an avatar of those socially embedded messages. Bodenhausen et al. observed that the amount of research scrutinizing the characteristics that explain affect concomitant with stereotypes is insufficient.

The experience of any clinician with social difference may be limited. It is not unusual for the work environment to be the primary contact for significant interactions between cultural groups. Awareness of this paradox informs the chosen method for engaging clinicians in a learning experience with diversity. In Patient Care Services at MGH learning experiences are experiential and interactive. The use of games, case studies, profiles of local communities and neighborhoods as well as educational offerings on topical events are a few approaches to making diversity "come to life" for staff and employees.

Healthcare Environment and Diversity

Part of the decision-making process in healthcare is to gauge the seriousness of signs and symptoms as a subjective report from the patient and the clinical distress they cause. An objective assessment of this account from the patient is the responsibility of the nurse and doctor. The consequence to this within the set of circumstances that constitute a cross-cultural interaction is the pivotal point of the following research.

The contemporary environment for clinical practice is fast paced and technologically sophisticated. A diverse patient population with multifaceted needs make care delivery intricate and often pressured. The discourse on economics of care presently joins the prevailing business case for care in the form of quality, safety, and evidence-based practice. Regulations and the debate for better-managed resources make the element of time an important factor that helps determine practice characteristics. The 20-min patient visit is a standard constraint on present-day practice, and as previously mentioned, short time frames facilitate the automatic processes involved with stereotype activation. This conceptual model of the healthcare environment represents the cross-cultural encounter and the environment that influences it (Fig. 4.2).

Sometimes the patient might not appear so different from clinician; however, situation awareness makes subtle difference more obvious. For example, Sally Hendricks, NP felt something was wrong as she handed her patient a prescription for the newest antidepressant medication to

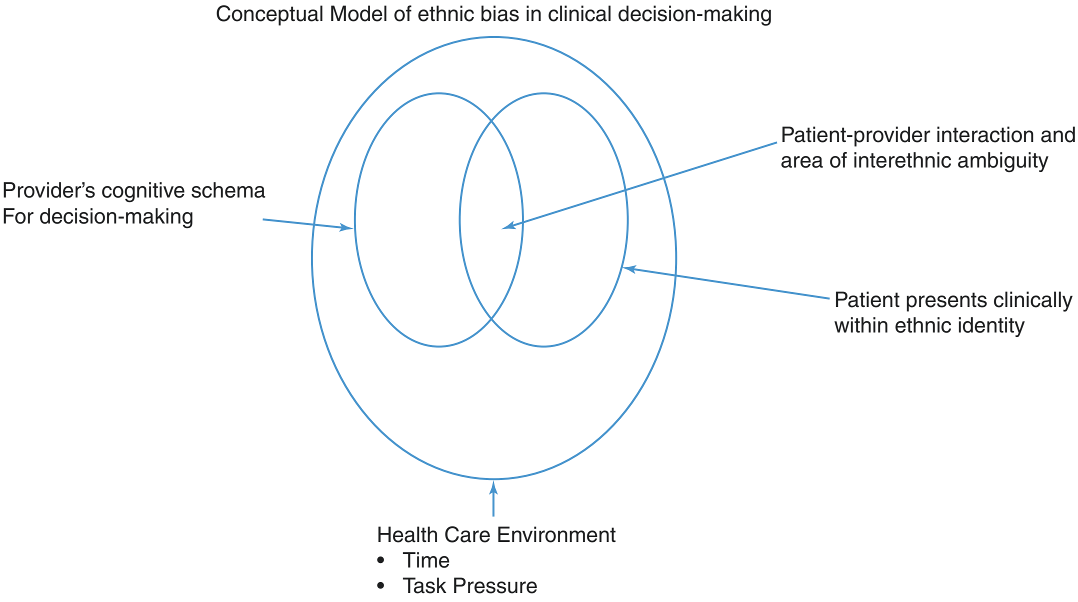

Fig. 4.2 Conceptual model of ethnic bias in clinical decision-making

hit the market. Calvin W, a 37-year-old restaurant owner, took a deep breath as he took the prescription, folded it, and slipped it into his pocket without looking at it. His raised eyebrow indicated that something bothered him, but the nurse practitioner could not identify the problem. He told her that he knew he had depression and his symptoms fully met the criteria for major depression, so the diagnosis was not the issue. The side effect profile of this new medication offered substantial efficacy with few side effects; therefore, fear of untoward reactions did not explain his reaction. Calvin W appeared to be middle class based on his attire and manners, so Sally did not suspect that he experienced a great deal of financial strain since the recession of 2008. Mr. W. happens to be struggling to keep his restaurant open and, at the same time, pay child support. Perhaps the stress of being a single man with responsibilities to his family and employees contributed to his depression; nonetheless, Sally did not realize he could not afford to pay for the prescription, which meant that he would not start treatment. Sadly, the nurse practitioner missed the socioeconomic issues that often become the proverbial “elephant in the room.” She assumed that he shared her middle class security.

According to the US Census of 2010, about 20% of the non-elderly population are uninsured [40]. Interestingly, of the uninsured, 46% are White, 31% are Hispanic, 16% are Black, and 5% are Asian American [40]. Today, more and more people are slipping from one socioeconomic class to a lower one, which causes embarrassment and a great deal of difficulty adjusting for that person and/or family. Moreover, a self-employed middle class person might not be able to afford insurance that provides the basic coverage a person on welfare receives for free. Cultural differences are often obvious, but not always. Calvin W came from a middle class White neighborhood like Sally, but circumstances caused him to slip down the socioeconomic ladder recently. Some patients feel uncomfortable talking about certain subjects, such as economic problems, sexual practices, and the like; nevertheless, clinicians may need to rely on situational awareness to recognize clues that something might be amiss and a cultural misunderstanding is in the making. Subtle signals, such as the ones above, indicate that a cultural bias might be impairing the interaction, which leads to major implications for effective treatment.

Aside from economic disparities, the National Healthcare Report from the AHRQ from 2011 indicated that Blacks and Hispanics with major depression were less likely to receive treatment during the 12-month observation period compared to Whites [40]. In addition, the report noted that Black adolescents and adults received treatment for alcohol and substance abuse problems more frequently than their White and native American counterparts [40]. Perhaps clinicians make stereotypic assumptions about certain racial or ethnic groups, and this translates into disparities in healthcare delivery. Such disparities might be avoided if clinicians challenged their biases through self-awareness in the doctor patient encounter. Thus, situational and self-awareness serve as the second part of the culturally competent care equation. However, self-awareness plus situational awareness does not necessarily equal culturally sensitive medical care.

Adapting: Changing Course in the Encounter

Another part of the equation involves adaptability. Of course, perceived similarities between physician and patient can enhance the dynamic relationship; however, patients within any cultural group show a wide range of individual variability [41]. Additionally, clinicians today frequently encounter patients from cultures and backgrounds quite different from their own. In either case the physician/clinician/researcher must adapt their approach to accommodate the sociocultural health beliefs of such varied patients [15]. Of note, patients who actively participate in medical visits tend to receive more responsive care from their physicians [42]. Patients become more active in treatment whenever the physician offers more facilitative interactions [15]. Physicians facilitate interactions with their patients by taking a reflective demeanor that adjusts to the patients cultural and personal beliefs while in the therapeutic moment of the appointment [15]. Although Schon suggests that such reflection and the subsequent adaptation to the situation should happen during the encounter, sometimes a reflection after the fact reveals aspects of situational and self-awareness that slipped past the physician during the busy visit [15, 43]. Adaptability integrates awareness with action.

Consider Dr. Nguyen's dilemma: Mrs. L. is a 63-year-old Hmong widow, who presented to the Ambulatory Care Clinic for the treatment of a possible urinary tract infection. The receptionist intentionally put Mrs. L. into Dr. Nguyen's schedule, because the initial screening information indicated that the patient emigrated from Vietnam, and so did Dr. Nguyen. Unfortunately, the receptionist did not know that Hmong people identify more with their ethnic background than a particular country. Fortunately, Dr. Nguyen did. Therefore, he paid particular attention to the patient's body language and facial expression to maintain situational awareness while filtering his stereotypic view of the Hmong people that he learned from his older family members to incorporate self-awareness into the interview. From the moment he met Mrs. L., Dr. Nguyen sensed that the patient seemed suspicious of him. Instead of jumping into a review of systems, he decided to shift and reminisce about the beauty of the Vietnamese landscape, which was so different than of East Boston. As Dr. Nguyen described some of his favorite places in Vietnam, Mrs. L. slipped into a smile as she nodded in agreement while Dr. Nguyen described the lush landscape around the region that the patient spent her childhood. Once he saw the smile, Dr. Nguyen then switched to a sadder tone of voice as he mentioned that he has never been able to find pho, a Southeast Asian soup, that tasted as good as pho he ate as a boy in rural Viet Nam. Although Dr. Nguyen knew little about the Hmong culture, he expected that she shared his disappointment of the American version of a Southeast Asian cuisine.

Of course, he hit the mark, and Mrs. L. started to explain her dismay of finding fresh ingredients for her cooking. Dr. Nguyen secured her trust without stepping into the quagmire of politics that likely caused Mrs. L. to act in a guarded and suspicious way with him at first. At that point, the review of systems and other medical information gathering flowed smoothly. Dr. Nguyen maintained situational and self-awareness and then adapted his approach to meet Mrs. L. on a human-level sharing pleasures and disappointment. This allowed Mrs. L. to relate to Dr. Nguyen as person, not someone possibly from another political party that persecuted her people after America withdrew troop from Vietnam.

Core Knowledge: Continuing Cultural Education

To complete the equation, a culturally competent clinicians must know about core cultural issues in the patients they treat [15]. Carrillo and colleagues suggest that clinicians should focus more on core cultural issues of an individual patient rather than culture of the group to which the patient belongs [44]. This prevents the clinician from relying on stereotypes related to such attributes as race, age, gender, religion, ethnicity, or socioeconomic status. The authors feel this applies not only to clinicians but also to researchers and educators as well.

Likewise, patients may identify primarily with one or two major features of their cultural background, i.e., a Chinese American man or a Latina woman from Costa Rica. However, such stereotypes only scratch the surface. Simply adding one layer, such as marital status, makes the cultural identity of these two individuals more complex. What if the Chinese American man were married to the Costa Rica woman in the example above? Of course, the plot thickens by adding one more layer. Now, imagine that they had a boy and a girl, who were fraternal twins. How would the children identify themselves from a cultural point of view? Might the son identify more with his father's Chinese heritage or the daughter with her mother's? Does their twin status impact their cultural identity? These and many more questions attest to the complicated interactions of different cultures in this hypothetical couple and their children.

Implications of Diversity and Clinical Practice

Recently, the United States and a number of other Western countries experienced major shifts in demographics due to immigration patterns. According to Annelle Primm, M.D., M.P.H., director of minority and national affairs at the American Psychiatric Association, minority births exceeded White births in 2011, and 50% of 3- and 4-year-olds were White, while the remaining 50% were non-White [40]. This means that today's majority may become tomorrow's minority. In the end, clinicians must acquire skills to manage patients from cultures other than their own. For example, a Black internist identifies herself as member of the minority, but she must understand core cultural issues of other minorities and even those of the majority group to facilitate a culturally sensitive medical encounter. With patients from so many cultures converging in waiting rooms, can anyone ever achieve enough knowledge to gain true cultural sensitivity?

Of course, assimilating knowledge about our patients' core cultural issues poses certain challenges, but technology provides part of the solution. Only a few decades ago, learning about the customs and mores of patients from foreign countries or different backgrounds than clinician's own typically required a trip to the library. Even a decade ago, the clinician would still need to find a computer to search the Internet for such information. Now, however, such information is at hand with handheld devices, i.e., smart phones, electronic tablets, and other devices.

Another source of information comes from colleagues. As the population grew more diverse, equal opportunity employment laws shifted hiring practices. As a result, the very homogenous White male medical staff of the 1950s evolved to the spectrum of diversity we see in medicine today. This diversity provides ready resources in our institutions for cultural consultation. To take full advantage of these resources, clinicians should think outside of their department and even their profession. For instance, John, a physical therapist, felt frustrated that Mrs. K. showed little motivation to complete the exercise program he prescribed each week. She came to live with her son in Texas after her husband passed away in Pakistan at age 80. Instead of giving up, John contacted Dr. Shah, an orthopedic resident from Pakistan, whom he met at a case conference 2 weeks earlier. Given that physical therapy requires a great deal of hands-on treatment, Dr. Shah wondered whether the patient's very strict Muslim background caused her to be uncomfortable with a man, other than her husband, holding her hand and touching her as John needed to do to help her during the session. He suggested that a female physical therapist might make her feel more comfortable in the aspects of therapy that required hands-on assistance. It did. John stayed involved with the case by giving verbal support, but Mrs. K. seemed much more motivated and comfortable with Cathy, one of the female physical therapists in the group, who took over the hands-on treatment. Colleagues offer a valuable resource for cultural consultations, so take advantage of their expertise even if that person works in a different department or area of your institution.

Possibly the best, cultural resource remains the patient. Most patients happily share information about their own culture within the context of the trusting relationship. As described earlier, suspicions about the motives of the clinician can be problematic. Building trust in the cross-cultural encounter becomes the foundation of a successful clinical experience. Avoiding questions that arouse concern about immigration or internal revenue agents is paramount. Begin the interview with benign questions, such as:

- What is the weather like in your hometown of Caracas at this time of year?
- I know that no one can cook as well as your mother, but do any of the restaurants in town serve Cambodian food close to the kind your mother made?
- How do you say "hello" in Cantonese?

Clinicians benefit from cultural curiosity. A question stemming from sincere interest suggests a receptive and supportive provider. Additionally, cultural diversity presents in a myriad of permutations. Individuals who appear to be culturally similar may differ in several significant perspectives, e.g., economic status, sexual orientation, or religion. Cultural curiosity often uncovers differences that otherwise might go unrecognized. The trusting patient will confide and reveal as a sign of confidence in the clinician.

A number of other political and social factors also play a role. Interestingly, advances in science and medicine have, in themselves, helped create cultural diversity. For example, patients now have access to medical procedures to transform themselves from one gender to another. Even though hormonal and surgical procedures result in remarkable physical changes, our understanding of the psychological isolation or marginalization experienced by patients at various stages of the transgender process requires much further research.

According to Hayes-Bautista, true cultural competence in medicine must hinge on large-scale, rigorous, science-based approaches to understanding the connections between culture, behavior, and epidemiology [45]. He points to the Latino epidemiological paradox to make his case [45, 46]. Latino populations show reduced risks for the top three causes of death compared to non-Hispanic Whites. The mortality rate in the Latino population is 35% lower for heart disease, 43% lower for cancer, and 25% lower for strokes [47]. Interestingly, these outcomes cannot be attributed to high income, higher educational levels, or easy access to the highest quality of healthcare [45]. However, careful investigation of Latino life, including diet, family structures, religious beliefs, and many other aspects of culture, might give clues to this paradox that could be used to improve the health of non-Hispanic populations [45].

Conclusion

Although this chapter presented a paradigm for providing medical care to patients from different cultural backgrounds and using examples of situations a clinician might encounter, other approaches to culturally sensitive healthcare delivery exist and work equally well. As described above, a successful clinical encounter with culturally diverse patients results from a simple equation in which the clinician uses effective communication aligned with situational and self-awareness. Adaptability multiplied by a core of cultural knowledge adds to the probability of success in the cross-cultural encounter. Race, religious beliefs, ethnic background, nationality, gender, sexual orientation, marital status, and numerous other aspects of social demographics give clues to cultural identity. Mental health providers, as well as all other persons delivering healthcare services, should understand the complex connections between each of these clues, so that interventions that would lead to better outcomes override those that might hinder treatment due to a lapse in cultural sensitivity. The population we treat appears so diverse, because of the amalgam of cultural traits that makes up each individual’s heritage. Moreover, each patient constructs a hierarchy of cultural traits in which one may overshadow another. For instance, is race more important than religious beliefs? (or lack of religious beliefs) The answer may be situational, culturally embedded, or irrelevant.

Intersectionality is an effective framework to bring focus to the underlying structure of information presumed to have bearing on the patient as a social being. Membership in a social group is fluid. This variability is greatly influenced by interactions loaded with the baggage of object lessons and representative patterns of behavior recognized from negative lived experiences. The issue for the clinician is the development of skill and understanding that serve as countervailing evidence that aspects of identity are not negative influences on the therapeutic encounter. Viewed as a problem domain, culturally sensitive care must point to methods and insights that produce solutions. Clinicians must demonstrate the conscious ability to express recognition of elements of identity as data. This data is defined as pieces of information that function to make more specific the meaning of perception, perspective, and reasoning within the context of the culture-based encounter.

The incorporation of the aforementioned data comes with a caveat. Unconscious bias may block cognitive dissonance. Absent the necessary knowledge and exposure to diversity, it is possible for the clinician to be incognizant of care compromised by bias or prejudice. This is especially true in decision-making that is unchecked and unchallenged. Clinical rounds, case presentations, and consultations become critically important education tools to develop expertise in caring for a culturally and linguistically diverse patient population. This type of proficiency requires a many-sided viewpoint and mind-set to form a therapeutic alliance. A frame of reference to approximate equivalent meaning is part of this skill building know-how.

The literature is replete with such subjects as implicit associations, cognitive load, aversive racism, and unequal treatment as indirect evidence of the impact that bias can have on the quality of care provided to ethnic minorities. However, to solve the problem of disparities, a paradigm shift in the approach to research is necessary. A more vigorous multidisciplinary strategy would advance the work with a renewed sense of urgency. Dovidio et al. [48] made the point that findings from social psychology and the health disparities literature are not organized into an interconnected knowledge base. In like manner, Drevdahl et al. [49] have offered the same research challenge to nursing stemming from its focus on cultural competence as the best-yet effectively unproven intervention to eliminate disparities. These authors have argued that in the discipline of nursing cultural competence, there currently lacks consensus on theoretical models, definition of relevant terms, or the identification of skill sets that define competence for clinicians. Until the nature of this specific competence is characterized, it will remain impossible to evaluate the situation that defines the point at which a clinician is operating at nothing more than a satisfactory standard. Fulfilling all requirements of safe nursing practice in the performance of autonomous decision-making symbolizes an entry-level execution of the concept that can be applied to mental healthcare. Clinical reasoning in nursing allows a great deal of latitude in scope of practice as an indication of expertise. On the other hand, cultural competence connotes a level of acumen that goes beyond what is merely adequate and moves practice forward to exceptional quality and ability. While not all disciplines favor the concept of cultural competence over cultural sensitivity, skill acquisition is more aligned with the former principle. The advancement of nursing practice is linked to its capacity to respond to a diverse patient population. To disregard this competence would be to have nursing practice remain in a fixed state and reducible to its past rather than its evolving relevance to the future.

In the end, mental health clinicians should develop a core of cultural competence to understand patients from diverse backgrounds, but they must exercise cultural sensitivity in interacting with each individual patient. No psychiatrist, psychologist, social worker, specialized nurse, or other mental health provider can possibly acquire a knowledge base adequate to understand all the nuances of ethnicity, race, gender, or other element of diversity that one will encounter in clinical practice today. Nevertheless, every clinician should be able to learn the important information specific to an individual patient so that each encounter with a patient evolves from a culturally sensitive approach and one relevant to the situation that caused the patient to seek treatment.

This chapter began with the example of President Obama. It appears apropos to end with a quote by President Kennedy:

> If we cannot end now our differences, at least we can help make the world a safe place for diversity. (John F. Kennedy)

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5

Cultivating Courage, Compassion, and Cultural Sensitivity in News Reporting of Mental Health During Challenging Times

Linda R. Zucker

Introduction

When invited to update the chapter on journalism for the second edition of this textbook on mental health and diversity, a question came to mind that the readership might also have: what wisdom can journalists impart to mental health professionals about diversity? What lessons have journalists learned navigating their profession's changing landscape that may translate well to those mental health professionals? This chapter will look at the ways in which journalists may (or may not) take into account the many facets of cultural sensitivity when covering mental health issues. It will also address mental health itself as a multidimensional diversity issue. While those living with mental illness are routinely discriminated against in society, mental illness itself discriminates against no one. It affects people of all races, religions, economic statuses, creeds, ethnicities, gender identities, and sexual orientations. The political climate has changed drastically in the United States since this book was first published in 2014. Healthcare coverage that afforded some assistance for those living with mental illness is quickly disappearing. Protections for LGBT individuals and families, along with women's rights, are in jeopardy at federal and state levels while our collective understanding of the challenges faced has increased. The media are attacked by the current Presidential administration in ways rarely witnessed in US history, yet the media have opportunities to help shine a light on the ways in which ordinary people may persevere with hope. It is through these lenses of complexity and layers of cultural sensitivity that this chapter aims to make the connection between journalism and mental health.

The chapter will discuss the case of Crownsville State Hospital, where news coverage that incorporated cultural sensitivity benefitted the individuals who lived there. The chapter also addresses the historical case of Nellie Bly, a journalist who was willing to have herself committed in order to expose the poor conditions of an early asylum that served women. The author reviews recent examples of how the print news media currently handles stories dealing with mental health issues for insight on what is helpful and what is potentially damaging or contributes to stigma for individuals living with mental health issues and the providers who care for them. In the wake of recent celebrity deaths, an analysis of how suicide is reported in news media and to what extent cultural sensitivity is considered relevant in that reporting is offered. Finally, a look at the #MeToo movement highlights ways in which social media are enabling cultural change to take place. By examining case studies, patterns, and histories,

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together we will explore ways that mental health professionals may learn from the evolving world of journalism. The chapter also brainstorms ways that journalists may collaborate with mental health professionals to increase awareness of cross-cultural issues within mental health and help reduce the stigma associated with one of the most marginalized populations in society, those living with mental illness. Looking at these cases from a journalism point of view, it is useful to understand the background of the field and what motivates the publication of news.

A Brief Overview of Journalism

News is a consumer-driven field. We inundate our customers with images, advertisements, news stories, articles, and information from an early age and nearly every day of their lives. For television news, ratings are important; for web sites, the number of hits received; and for newspapers, books, and magazines, the number of copies sold. There is no single governing body setting forth a comprehensive strategy and direction for our field providing guidance on what we should do to pique the public interest, nor any one set of ethical standards we use to navigate the nuances of cultural sensitivity in news reporting or education. Major news producers tend to have their own specific ethical guidelines. For example, *The New York Times* has set forth a company policy on ethics in journalism that it makes available to the public. Gannet's newspaper division implemented similar guidelines in 1999. In the past two decades, more professional organizations and nonprofits have emerged to provide model ethical guidelines to encourage and support journalists in adopting a global mindset [1, 2], but this typically does not include guidelines for reporting with cultural sensitivity. The professional organizations supporting greater diversity in journalism have developed guidelines for reporting, such as Unity: Journalists of Color, the Native American Journalists Association, the National Lesbian & Gay Journalists Association, Arab and Middle Eastern Journalists Association, the Maynard Institute, and the Poynter Institute [3–7]. Each of these organizations aims not only to increase the diversity within journalism as a profession but also to improve cultural sensitivity by increasing the diversity of reporting on issues that are relevant to people of different cultural backgrounds.

The Associated Press Style Book also provides a basic framework for reporting and colloquial usage of terms for news reporting but it is largely focused on consistency rather than professional responsibility or ethics [8]. Theoretically, we are more accepting of cultural differences and backgrounds today in part because the population in our country is changing over time, so we may reasonably expect that our news environment and stories would mirror this evolution we have experienced. Are there more women and people of color and LGBTQ people represented in the media today? Is there greater coverage of people of different ethnic and religious backgrounds? The American Society of Newspaper Editors had a goal of matching newsroom demographics to that of the population by the year 2000 [9]. Examining the current landscape of media employment shows that there are still significant gaps in these areas and while some areas have shown slight improvement, the field did not meet The American Society of Newspaper Editors' goal. For example, according to US Census data, women make up more than half of the population [10]. Yet they hold only 39% of all positions in the media [11]. Though African-Americans make up over 14% of the US population, only 4.68% of journalists in the United States are black [10, 12]. An analysis by media watchdog organization the fourth Estate of the front-page news coverage during the last election cycle reveals that 93% of front-page print articles about four major policy areas—economy, social issues, foreign policy, and immigration—were written by Caucasians [13]. Less than 20% of the writers across most major newspaper outlets were black, Latino, and Asian journalists [13]. *The Dallas Morning News* stood out as a leader in diversity during the 2012 election cycle with 18.8% of their front-page articles written by black reporters [13].

Increasing the diversity of journalists may help to bring new perspectives and cultural awareness, but larger, systemic shifts may be needed to bring about real change. Newsworthiness is an important criterion in whether a story gets published. What makes a story newsworthy? A story that is interesting enough to the general public to warrant reporting is the dictionary definition [14]. Events or articles involving celebrities, politicians, and professional athletes are often newsworthy. Stories with a local tie or personality may be considered newsworthy. Narratives involving drama, conflict, violence, immediate public health and safety issues, or new scientific discovery may also meet a definition of newsworthiness. Most major media outlets in the United States are owned by corporations and must be convinced to see value in the stories and struggles of ordinary people living their lives with mental health challenges. By reporting on these individual stories, journalists can help to overcome the stigma associated with mental health issues and bring about a cultural shift that can contribute to the growth and evolution of the mental health system.

Journalists, like mental health professionals, are human beings who have feelings, beliefs, and backgrounds that help shape the way they see the World. Having this understanding may help journalists come to a place of impartiality that is so critical to sound news reporting. While impartiality and neutrality in news coverage is important, some in the field, particularly bloggers, are making themselves and their personal motivating factors for reporting (though generally still avoiding partisan views) more accessible and transparent to the public through the use of social media [15]. Rebecca Skloot, a science journalist, took exactly this approach in covering the story of Henrietta and Elsie Lacks in her book, *The Immortal Life of Henrietta Lacks*.

Case Study: Rebecca Skloot and "The Immortal Life of Henrietta Lacks"

Rebecca Skloot's international best-selling book chronicles the life of the woman behind medical history's most famous tumor cells [16]. A 16-year-old Ms. Skloot learned about HeLa cells in her basic biology class in the late 1980s [17]. Her teacher gave her few pieces of information about the cells they were experimenting on: they were from 1951, the woman they came from died of cervical cancer, her name was Henrietta Lacks, and she was black [17]. Mrs. Lacks' cells have been used for cancer research, the development of the polio vaccine and other drugs, human longevity, and more research topics and discoveries than can be covered in this chapter [17]. The young Ms. Skloot was upset—"That's it? That's all we get? There has to be more to the story," she recalls thinking and began a search that turned up little information—a footnote in a biology textbook, no entries in encyclopedias or other resources [17]. Yet the seeds of inspiration were planted. Ms. Skloot became "fixated on the idea of someday telling Henrietta's story" [17]. Ms. Skloot was willing to spend over 10,000 dollars of her own funds and many months of her own time doing research, getting to know the Lacks family and helping family members learn the truth about what happened to Henrietta, along with her daughter [17]. Mrs. Lacks died in 1951 and very little was known about her until Ms. Skloot's research. Few articles were written about Mrs. Lacks and her story was not widely published until 2010 [18–20]. In a *Jet* magazine article, Dr. J.E. White is quoted as saying "It is incidental that Mrs. Lacks was black," while Dr. W.M. Cobb found there to be poetic justice that an African-American woman would contribute so heavily to cancer research [20]. A Google search of Henrietta Lacks returns close to one million results—far more than the footnote of the 1980s. It is important to recognize that Henrietta's story did not get told because a newsroom executive decided this was headline news and deserved prime coverage. In fact, complex issues such as race, economic status, and illness may have all contributed to why Henrietta's story was not fully told before Ms. Skloot decided to make telling it a personal priority. Ms. Skloot used several thousand dollars of her own money to fund research for the book [17]. Mrs. Lacks was a descendant of slaves—a tobacco farmer living in the rural south at a time when African-Americans still faced severe discrimination in medical care and employment [17]. She died 4 years before Brown v. Board of Education paved the way for greater equality in public education. Though the Nuremberg Code existed at the time of Henrietta's treatment for cervical cancer, physicians sampled her cells and shared her medical records without obtaining the informed consent that we recognize as a right in today's world [17]. Mrs. Lacks' cells have made billions of dollars for laboratories while her descendants could not afford basic medical care [17, 21]. After reading about Mrs. Lacks' life and death and the challenges her children face, it is clear that there is a great deal of injustice in this story. Ms. Skloot's personal passion and desire to communicate this family's story is what brought the history of the Lacks family to the public eye.

As part of her commitment to the Lacks family, Ms. Skloot searched for information on what happened to Elsie Lacks, Henrietta's second child. During the research process, Ms. Skloot discovered some details about Elsie's brief life. The information she uncovered provides a window into the horrific conditions young Black children were subjected to in mental health facilities of Elsie's time. Elsie was born with epilepsy and had an inherited hearing impairment [17]. No one taught Elsie sign language, so she was limited in her ability to communicate [17]. The year before her mother began treatment for cervical cancer, Elsie was placed in Crownsville Hospital, which was formerly known as the Hospital for the Negro Insane. The conditions of this institution were so deplorable that *The Baltimore Sun* published a series of articles entitled "Maryland's Shame," in 1948–1949 detailing the experiences of young African-American children in the overcrowded facility that Elsie Lacks was likely subjected to until her death at the age of 15 [22]. What is poignant about the timing of *The Baltimore Sun* exposé is that the genocide and tragedy of the Holocaust was still fresh in the minds of Americans. In 1946 and 1947, several employees of Germany's Hadamar Clinic were convicted of the murders of mentally ill patients under the Nazi regime's notorious T-4 program [23]. The day Mrs. Lacks went to the hospital for tests is the same day that the government pardoned 21 German war criminals who were originally sentenced to the gallows [18]. By this time, stories of how women, children, people of different ethnicities, those with physical differences, gay, transgender, lesbian individuals, and the mentally ill were treated in Nazi Germany during World War II had been prominently featured in US newspapers. It is reasonable to imagine that American readers may have drawn parallels to what they were learning about victims of the Holocaust and what was being revealed about how people were being treated in their own nation under the guise of mental health care.

The Crownsville Hospital was known as a dumping ground for children with mild disabilities [24]. Tuberculosis infections were rampant at the hospital and in the winter months, there was no way for those affected by TB to be quarantined from the healthy residents, likely causing the epidemics that occurred there frequently until the late thirties [24]. The hospital served African-Americans, yet during Elsie's tenure only one or two African-American staff members worked at the facility. The hospital would not have any African-Americans in direct patient care roles until long after Elsie passed away [24].

Unlike many of the other residents of Crownsville, Elsie's mother visited her weekly until the cancer treatments prevented Mrs. Lacks from doing so [17]. Mrs. Lacks saw Elsie as clean and well-cared for during her visits [17]. However, the children were housed alongside ex-prostitutes, criminals, and violent patients without regard to safety and well-being [24]. Young girls were huddled in a playroom that contained no toys [24]. There was insufficient funding for the hospital and the residents lacked proper clothing, food, and access to toilets and bathing facilities [24]. Despite the climate of discrimination and racial tensions in the 1940s, *The Baltimore Sun* dared to report the disparity in treatment between black and white residents at mental health facilities. This in-depth reporting and news coverage led the state of Maryland to allocate increased funding for the residents at Crownsville and inspired the formation of The Golden Rule Guild, an organization of women mental health advocates that still exists today [25].

Ms. Skloot's journalistic success with the publication of The Immortal Life of Henrietta Lacks highlights a path for propelling a compelling story into the realm of public awareness. News of her book and the Lacks' story made *The New York Times* best sellers list, along with being featured on Oprah and in most other mainstream news outlets [16]. Papers like *The New York Times and The Washington Post* often set the standard for journalism and has widespread readership around the world. Millions of viewers watched Oprah's show or read articles in her popular *O!* magazine. When CNN or other large networks pick up a story, the number of people who have access to the information increases exponentially. The Internet adds to the fanfare and provides countless other opportunities for information sharing and distribution. Ms. Skloot made good use of these tools to promote her book and encourage the public to learn about the life of Henrietta Lacks. Individual passion and a willingness to spend her own time and money, rather than the usual profit motivation that is often associated with journalistic enterprise, helped Ms. Skloot's telling of Henrietta Lacks' story to reach millions of people.

Case Study: The Asylum at Blackwell's Island

In today's world, the title of Nellie Bly's book, *Ten Days in a Mad House*, does not evoke a sense of cultural sensitivity on its surface. Terminology like "mad house" would no longer be used to describe a mental health facility as cultural sensitivity is of greater importance now. In 1887 when it was published, it represented a female journalist's act of courage in investigative reporting and had significant impact on the lives and well-being of women who were institutionalized at the Women's Lunatic Asylum at Blackwell's Island.

Bly wrote for *The New York World*, where her book was originally published as a series of articles [26]. Prior to this, she had reported on the plight of female factory workers before being her editors relegated her to the "women's pages," to report on fashion [27]. Dissatisfied, she traveled to Mexico to report on the customs and culture of the Mexican people until the Mexican government threatened her with arrest for speaking out against the detainment of a fellow journalist [27]. Her work followed a string of press stories preoccupied with Blackwell's Island and its residents [26].

Women during this time period were particularly susceptible to diagnosis of various mental disorders whether or not they were actually suffering from any mental health issues, including female hysteria [28]. Bly feigned mental illness by going to a charity home for women and complaining that she felt the other women there were crazy and that she was frightened of them [29]. This behavior escalated to speaking in Spanish, inquiring about lost articles that never existed in the first place, having amnesia and was enough to convince a judge, a doctor, and several mental health professionals that she should be committed—first to a mental hospital and then transported to the asylum on Blackwell's Island [29]. The asylum at Blackwell was intended to be a forward-thinking facility that was governed by theories of moral treatment but that vision was never realized, with rampant overcrowding. The construction of the facility only being partially complete, convicts from the local prison were brought in to supervise and guard the patients [26]. While a patient in the asylum, Bly witnessed and experienced firsthand the cruelty of the nurses, the inadequate facilities, and spoiled food [29]. Her book details the stories of fellow patients, some of whom were not mentally ill at all but could not convince the doctors or nurses to take their stories seriously enough to reevaluate their admission or status in the asylum [29]. Bly began to realize that any woman placed into the conditions at Blackwell in 1887 would develop insanity with a little time.

> What, excepting torture, would produce insanity quicker than this treatment? Here is a class of women sent to be cured. I would like the expert physicians who are condemning me for my action, which has proven their ability, to take a perfectly

> sane and healthy woman, shut her up and make her sit from 6 a.m. until 8 p.m. on straight-back benches, do not allow her to talk or move during these hours, give her no reading and let her know nothing of the world or its doings, give her bad food and harsh treatment, and see how long it will take to make her insane. Two months would make her a mental and physical wreck.

Ms. Bly would attempt to engage the physicians and nurses about the conditions and was met with limited compassion mostly from the doctors who cared for her during her stay [29]. Once in the asylum, the more Ms. Bly acted and spoke in a way that was reflective of her normal self (no longer keeping up the guise of mental illness), the more insane the doctors and nurses found her to be. Ms. Bly was finally discharged from Blackwell's Island after an agent from her employer, *The New York World*, contacted physicians. Upon release from the asylum, Ms. Bly was called to testify before a grand jury. During her testimony she spoke of her experiences at Blackwell's Island and the atrocities she witnessed there [29]. Some staff members from Blackwell's Island who were also called before the grand jury gave contradictory accounts not only when compared with Ms. Bly's story but also each other's [29]. Ms. Bly's journalism and grand jury testimony helped influence policy at the Blackwell facility [29]. Women were no longer immersed in cold water to bathe [29]. They were provided with more clothing, blankets, and higher quality food [29]. Dubious practices, such as having a lookout to watch for the doctors while the nurses abused the patients, were put to an end and staff members who arranged for such things were dismissed from their jobs [29]. Amidst public outcry and institutional embarrassment over the charges, a large allocation of funds—$850,000—was provided to the Department of Charities and Corrections [30]. Throughout our nation's history, journalists like Ms. Bly and Ms. Skloot have had the ability to help raise public awareness and bring important issues to the forefront of civic debate. When journalists report in a way that is inclusive of cultural sensitivity, the stories have the ability to transcend stereotypes and strike a chord even within the most skeptical of minds.

Additional Modern Mental Health Coverage and Diversity in the News Media

The ways in which journalists frame the news is a critical component of how the stories will be understood by consumers. "Frames help us to make sense of our life experience—they are internal cognitive structures that allow us to locate, perceive, identify and label," what we encounter [31]. An explanation applicable to the news is that a frame "is the way information is presented and organized in the media and interpreted by the individual," [32]. A 2005 study of 70 major US newspapers found that 39% of the articles discussing mental illness focused on various frames around associating mental illness with the concept of dangerousness [33]. Studies have shown that people are influenced by what they read in the news and see on television and that depictions of mental illness as dangerous can increase the stigma associated with mental illness [34, 35]. If the largest single category of mental health news reporting is around telling stories that warn of danger of those with mental illness, how does this impact the 26% of stories that are related to treatment and recovery from mental illness? [33] If the plurality of mental health articles focus on dangerousness, readers may be more likely to dismiss or disassociate from the more positive stories that focus on the benefits and options for treatment and recovery from mental illness [34, 35].

Mental illness often comes up in the United States news as a possible explanation for or contributing factor to a crime, such as gun violence or murder [36], even when the perpetrator may not have had a diagnosed mental illness.

When looking to other Western nations, the picture does not get more positive—studies in Australia, New Zealand, the United Kingdom, Canada, and Germany have yielded similar findings [34, 35, 37–39].

There are few recent comprehensive studies that look at media coverage of mental health from a cultural sensitivity perspective, especially those done by journalism schools. Most of the studies performed in the early to mid-2000s on media and mental health appear in psychiatric and medical journals rather than in literature written by and for the academic journalism community. One may speculate that this is because journalism is frequently about interviewing and reporting on people and scholarly journals are often focused on rigorous academic topics and perhaps less concerned with individual stories. The mental health community recognizes that cultural awareness and sensitivity plays a role in an individual's ability to seek treatment, and this frame could be useful to reporters who are covering mental health issues and stories for the news [40]. Recent studies include the effect of media coverage on public perception of events such as mass shootings [41], as well as [42]. Additional studies specific to mental health and shootings in the United States are emerging in the fields of law, criminal justice and forensics. As public shootings increase, so does the academic activity examining those tragedies; however, the bulk seems to fall outside of the realm of journalism.

Younger generations are identifying as multicultural and may be willing to be more expansive in their views of the world. College newspapers are willing to cover mental health issues and some have done so from a compassionate or thought-provoking perspective [43, 44]. One example is a thoughtful article published in *The Columbia Spectator* in 2009 that emphasizes the importance of cultural considerations and the role they play in determining how and whether a person will choose to seek mental health treatment [44]. The article provides a diverse array of examples from a Somali immigrant's family who had to consider stigma and superstitious beliefs about mental illness when choosing to seek help for their autistic son. It also discusses a Jewish community's practice to speak with a Rabbi about mental health issues before seeking a mental health practitioner's help. Disparities in access to mental health services were also shown between Black and White populations [44]. Similar information has appeared in academic and medical journals before but those articles are less accessible to the general public. The Internet makes some free stories more available but many academic articles remain locked by pay-per-use fees. *The Columbia Spectator* serves thousands of students and community members at several New York colleges and is also available online. Another article in the University of Connecticut's newspaper explores themes of mental illness being sexualized or depicted in a glamorous way, particularly when involving female characters [43]. Though the readership of a college newspaper may be limited to the academic institution it serves and the surrounding community, it is encouraging to find that journalists-in-training are willing to address subjects that they may have a greater challenge in covering post-university.

"We have to get the word out that mental illness can be diagnosed and treated, and almost everyone suffering from mental illness can live normal lives," is a quote attributable to Rosalynn Carter, one of the founders of The Carter Center. The Carter Center's compelling motto is, "Waging Peace, Fighting Disease and Building Hope" [45]. In addition to the many mental health improvement initiatives it funds, The Carter Center also offers a fellowship program for journalists from around the world with the goal of helping improve the public's understanding of mental health issues, reducing stigma and eliminating the discrimination toward people living with mental health issues [45]. The fellowship has resulted in journalists having the financial means to publish quality work on mental health issues [45].

The New York Times has a dedicated section on mental health that sets a strong standard other journalistic institutions could benefit from considering. Their approach is distinctive because of its focus on people who are living with mental illness—and the emphasis is on living, not the mental illness [46]. In the recent *The New York Times* feature, *Lives Restored*, stories of ordinary people with mental illness provide hope and inspiration for those living with mental illness, as well as offer an opportunity for readers to develop empathy and awareness. Two of the five interactive stories featured have been from people of color who have learned to deal with mental illness and live meaningful lives. Stories like these are helpful because they demonstrate that mental illness can affect anyone and that there are ways of coping that are positive and life affirming, allowing those impacted by mental illness to have successful professional lives, families and contribute to society and their own sense of well-being. The interactive feature format allows readers to see footage of the people, putting a face on common mental health concerns, hear the voices of diverse backgrounds and lives, and read more extensively about each person's story in a more traditional webpage article.

Case Study: Youth, Bullying, and LGBTQ Issues

Students will hear anti-gay bullying or gender-based slurs up to 26 times per day at school [47]. This type of bullying affects not only those students who identify as lesbian, gay, bisexual, transgender, questioning or queer (LGBTQ) but also has an effect on all students. Being bullied on the basis of sexual orientation is a form of sexual harassment, according to Dr. Dorothy Espelage, a University of Illinois professor [48]. Bullying creates an unsafe environment for children to learn and to thrive in. Massachusetts, like many states, has witnessed the effects of bullying on school children.

In 2009, 11-year-old Carl Joseph Walker-Hoover hanged himself by an electrical cord in his Springfield, Massachusetts home while his mother cooked dinner [49]. The African-American preteen did not identify as LGBTQ, but was teased relentlessly by his peers at school being called gay or effeminate [50]. His mother worked to ensure that the school was aware of the bullying and joined the local Parent-Teacher Organization in an effort to put an end to it [51]. She was aware that her son's behavior had changed and that he was getting into some trouble at school but did not anticipate that he would end his life [51]. Walker-Hoover's suicide and youth bullying was covered in local, state, and national news [50–52]. In an effort to begin "…A national conversation on bullying," Oprah Winfrey spoke with Carl's mother, along with the parents of other bullied teens in May 2009, bringing in experts to help provide guidance to those students dealing with bullying in the classroom [48]. News coverage around bullying has raised awareness of the prevalence of anti-LGBTQ bullying in the schoolyard and online [53]. Ten or twenty years ago, it may have been hard to imagine a national dialogue around student safety and anti-LGBTQ bullying. Now, institutions like Michigan State University School of Journalism are taking the initiative to raise public awareness of bullying through news coverage projects and book authorship [54, 55]. CNN reporter, Anderson Cooper, who is openly gay, won an award from the National Gay and Lesbian Journalists Association in 2012 for his Anderson 360 series titled "Bullying: It Stops Here" [56]. With the increased attention and focus on the impact that bullying has on young people, legislators at state and national levels are closely examining what can be done to help reduce and eliminate the sources of harm by making schools safer places. Massachusetts' anti-bullying legislation went into effect on May 3, 2010 [57].

Case Study: Mental Illness as White Privilege

Previously, we have examined ways in which mental illness is used by the media to disparage or create fear of those with mental illness. However, mental illness can also be used by the media to explain away the motivations of people who commit reprehensible crimes. It is important to define what is meant by white privilege. TeachingTolerance.org has the following to say about white privilege: "White skin privilege is not something that white people necessarily do, create or enjoy on purpose. Unlike the more overt individual and institutional manifestations of racism described above, white skin privilege is a transparent preference for whiteness that saturates our society. [58]" The concept of white privilege is one that can ignite controversy and denial, yet it is important to look at in the context of news reporting of crimes. When journalists cover active shootings in the United States, racial, ethnic, and mental health stereotypes are often implicated. [59] conducted a study to review a sample of 170 stories, in which the words "mental illness" were used to describe white shooters' behaviors 80% of the time, yet only 16% for black and 4% of Muslim shooters. When reporters portray mental illness as the cause of a shooter's actions, they are promulgating a narrative that the shooter is more entitled to compassion or understanding than if they were to portray that same shooter as a thug or as a terrorist, which was overwhelmingly the case for non-white shooters [59]. *The Washington Post* noted that language used by mainstream news media outlets to describe Dylan Roof, who shot nine African-American churchgoers, centered around the idea that Roof was "mentally ill" in an effort to humanize the white shooter, rather than refer to him as a terrorist who targeted peaceful, praying minorities because of the hatred he had for them [60]. They cited other examples where reporters portrayed white shooters as "mentally ill," while black victims of shooters were described as violent or somehow culpable for or contributorily negligent in their own deaths, even when those victims were children [58, 59]. This tendency to vilify non-white victims is troubling and shocking to the conscience. It is difficult to comprehend what purpose this style of reporting has that serves any public good or even newsworthy purpose, other than perpetuating a racist narrative. Shooting victims who are Caucasian are not vilified in this manner or held responsible for their own deaths. One can argue that it is inappropriate for journalists to diagnose the mental health of their news subjects unless the information is coming from a psychiatrist or psychologist familiar with the individual, which would likely give rise to physician-patient confidentiality issues that would prohibit reporting on such material [61]. One study found that very few media professionals had received any mental health awareness training, so reports ascribing mental illnesses to white shooters are more often based on speculation rather than facts. Additionally, a June 2018 FBI report which examined the pre-attack behaviors of active shooters in the United States for a period of 13 years found,

> Some studies indicate that nearly half of the U.S. population experiences symptoms of mental illness over their lifetime, with population estimates of the lifetime prevalence of diagnosable mental illness among U.S. adults at 46%, with 9% meeting the criteria for a personality disorder. Therefore, absent specific evidence, careful consideration should be given to social and contextual factors that might interact with any mental health issue before concluding that an active shooting was 'caused' by mental illness. In short, declarations that all active shooters must simply be mentally ill are misleading and unhelpful, [62].

To facilitate a more fact-based dialogue, journalists must be willing to face their own biases and understand how those biases shape the news they report. In 2017, there was a record number of 30 active shootings in the United States [62]. Journalists have a responsibility to transform harmful narratives that reinforce dangerous racial and ethnic stereotypes. Mental health professionals have an opportunity to partner with journalists to help them understand mental illness and the role it does or does not play in violent events such as mass shootings.

The #MeToo Movement

Tarana Burke, a sexual assault survivor who sought to help other women and young people of color who had also survived sexual violence, started the MeToo Movement in 2006 [63–65]. At that time, approximately 5% of Americans used social media [66]. Over a decade later, social media use jumped to nearly 70% of Americans and #MeToo began appearing on social media in connection with stories of sexual assault and harassment experienced by celebrities. High-profile cases in film, television, US gymnastics and politics emerged, along with stories of everyday women all over the world. Social media sites became platforms for women to break their silence around sexual violence and also enabled males and other genders to witness these stories and offer support. The visibility of #MeToo and the women sharing their experiences also helped to highlight the amount of trauma that many women from all walks of life are living with [67]. Within the first 24 hours of #MeToo going viral, over 12 million people engaged with the hashtag on Facebook alone [64]. The coverage was not completely positive, as many comments scrutinizing the clothing women wear, how women behave, having male friends, whether a particular woman was believable also emerged in the discussion, which can have the effect of re-traumatizing survivors of sexual violence and distorting or shifting the focus away from the causes and perpetrators of violence [67]. The pace at which the movement grew caused a risk of the original voices behind #MeToo being drowned out. Using the same social media platforms that many Caucasian women were leveraging to speak about their experiences, Tarana Burke was also able to voice her concerns about women of color being included in the conversation that they started long before the viral social media hashtag gained traction [64, 65]. The movement gained so much attention that Time magazine named The Silence Breakers, acknowledging Tarana Burke and several others in the #MeToo Movement as its 2017 Person of the Year [68]. By January 2018, over one million people marched in Washington D.C. for the second annual Women's March "to harness the political power of diverse women and their communities to create transformative social change," [63, 69]. As of the publication deadline for this textbook, more allegations have surfaced, investigations are taking place, conversations are occurring on prevention and treatment and perpetrators are increasingly being held accountable for sexual violence.

Cultural Sensitivity in News Reports of Suicide

A mental health topic that tends to receive strong coverage is suicide. When a celebrity or professional athlete commits suicide, it makes front-page or headline news, as witnessed with the June 2018 deaths of fashion designer Kate Spade and author, TV personality, and culinary ambassador Anthony Bourdain [70, 71] or comedian Robin Williams' death in 2014 [72]. There are differing opinions about how much information should be covered when a suicide has occurred [73]. Journalists are advised to be aware that news of suicides can inspire copycat behavior in others who are contemplating suicide and to avoid reporting that could be interpreted as romanticizing the behavior [73]. What is less known about these stories is to what extent the reporter covering them has taken cultural sensitivity into account. Suicide is a topic in some cultures that may not receive adequate attention because of personal or societal beliefs that either condone or condemn personal acts of suicide. Journalists may want to be sensitive to these cultural nuances and how they may affect the communities, families, and groups dealing with the aftermath of a suicide. Suicide carries with it great pain for the families and friends left behind, as well stigma that is pervasive in American society and many additional cultural backgrounds. President Obama recently ended the military's practice of not sending condolence letters to the families of service members who took their own lives, in part to "de-stigmatize the mental health costs of war to prevent these tragic deaths." Some religions believe that suicide is immoral or an act against creation [74]. One study suggests this may have a beneficial effect in the course of treating individuals with bipolar disorder due to the closer-knit religious communities helping individuals feel less isolated and more likely to seek help and support [74], though for individuals with other mental health issues, a moral or religious stigma may not be a helpful factor. For the surviving family members of those who have lost loved ones to suicide, this type of stigma may prevent them from receiving the care they need to cope with their grief [75]. Some religions have changed their practice or doctrine around how to treat suicides and offer hope and help for families and friends by taking into account mental illness [75]. There has also been some journalistic effort to dispel the myth that African-Americans don't commit suicide. Journalist Amy Alexander and Harvard Psychiatrist, Dr. Alan F. Poussaint co-wrote the book *Lay My Burden Down: Suicide and the Mental Health Crisis Among African-Americans* [76] in which they explore their respective, deeply personal experiences with family members who committed suicide, along with the broader cultural and societal factors that contribute to a disparity in mental health treatment for African-Americans. The book received broad coverage when it came out in 2001 with prominent features in *The New York Times* and *Washington Post* [77, 78]. Follow up stories on NPR and a blog for *The Clarion Ledger* newspaper leveraged Poussaint's expertise [79, 80]. When Don Cornelius the creator of the popular 1970s show Soul Train committed suicide in 2012, the issue of African-American beliefs around suicide were raised once again, with Clarence Page, whose ex-wife had earlier taken her own life, stepping out with a call to "shatter the black suicide myth" [81].

In both cases, the journalists' willingness to share their personal stories brought attention to a mental health issue. This is precisely what happened with both Nellie Bly and Rebecca Skloot—where the individual journalists' own reasons for reporting the news provided the foundation for elevating mental health issues to a place of greater public awareness.

There are ways for journalists to report with integrity and ethical standards that can also support broader cultural shifts. News reporting standards for journalists that include cultural sensitivity and awareness may lead to greater public awareness. The Poynter Institute, in partnership with several mental health organizations, has helped publish Recommendations for Reporting on Suicide that have been featured on CNN and other major media outlets [82, 83]. Included among them are using neutral headlines and photos of the individual, describing suicide trends accurately rather than sensationalizing, using passive voice, including information on the warning signs of suicide and messages of hope, and including information on prevention [82, 83]. With the deaths of Anthony Bourdain and Kate Spade, much of the media coverage included the contact information for the National Suicide Prevention Lifeline and encouraged readers or viewers to seek professional help if needed. The Poynter Institute also reminded the news media that there is opportunity to reinforce a message of hope during these times that may help others considering suicide [84, 85]. The final section of this chapter will explore ways that journalists can improve professionally, as well as how mental health professionals can benefit from or be a part of that process.

Opportunities to Improve Efforts Around Mental Health and Cultural Sensitivity in the Media

In Zanzibar, the Muslim community has a practice of helping people whom Westerners would diagnose as schizophrenic primarily through compassion, support, and inclusion [86]. Words of the *Qur'an* are written on the inside of their cups so they drink the words of healing [86]. The community believes in appeasing the voices with dance and song as a means of healing, so the individual is exposed to art and activities with others that they would likely be excluded from if were they coping with schizophrenia in Western culture [86]. This story came from an academic journal, not a work of news journalism, yet it provides an intriguing model for the different ways journalists may want to choose to cover stories around mental health. One way to provide unique coverage to mental health professionals may be to look at the history, traditions, and cultures of people in and outside of the United States for insight and information. This approach could prove useful for mental health professionals, as well. What is acceptable by our larger society today was not necessarily acceptable decades ago, nor is there any guarantee that what is acceptable today will be tomorrow. American culture is a melting pot of the indigenous peoples who originally lived here, along with the many peoples who have found refuge here throughout the centuries. Rather than dismiss different belief systems, journalists and mental health professionals may want to carefully seek to understand the allegory, symbolism, and wisdom that each has to offer because this directly relates to our ability to effectively and accurately tell the stories of the people we represent. Through understanding the traditions, beliefs, and practices of different nations and cultures, journalists and mental health professionals may also find practical and unexpected guidance on how to approach the topic of mental health more creatively and compassionately in the art of telling peoples' stories or creating a nonjudgmental and inclusive environment for a client to tell his/her story.

Journalism schools need to take a greater role in teaching topics of diversity, cultural sensitivity, and mental health in their academic institutions and increase research in the industry to understand the news being produced. The availability of news via blogs and the Internet opens up so much potential for understanding and information sharing. Modern journalism research could uncover more promising data on the diversity of the profession. Research is also critical to inform educational practices and teaching needs that could translate well to the university classroom environment. Better research could lead to an increase in funding for fellowships or other educational initiatives that offer experiential-based learning opportunities for journalism students to get real-world reporting and editing exposure in a climate that enables them to incorporate cultural sensitivity in the newsroom.

Several journalism schools in the United States have formed ethics centers or programs of study, such as The University of Michigan, The University of Wisconsin and Santa Clara University. Cultural sensitivity may be a comfortable fit within an ethical paradigm. If budding journalists have a greater understanding of the importance of cultural sensitivity, then this knowledge can be woven into the reporting they carry with them to internships and later, the professional arena.

More news organizations could take the approach of *The Dallas Morning News* and extend opportunities to journalists of diverse backgrounds. Having a more diverse workforce alone will not necessarily improve the quality of coverage of mental health issues but it is a step in that direction. News organizations could amend their standards to be inclusive of cultural sensitivity and provide training to existing staff that emphasizes the importance of diversity in reporting as well as our global society.

On an individual level, journalists may seek to partner more closely with mental health professionals to inform perspectives on a story. Scholars and physicians alike believe that integrating mental health professionals into journalism as experts or commentators could greatly improve the awareness that the journalist has on the particular mental health issue being covered but may extend to a more balanced story reaching the public, as well [87]. Greater collaboration and interaction between mental health professionals and journalists may help inspire the kind of personal passion necessary for helping elevate issues and stories to a larger audience. Mental health professionals' input in the media may help reduce the stigma associated with mental illness and increase the data available to the public about options for treatment.

Concluding this chapter without a mention of a growing and controversial population of reporters would overlook contributions that the populace can make to journalism, mental health, and cultural sensitivity. Ordinary citizens may help present creative ways to cover challenging topics something from which both journalists and mental health professionals can learn. Almost anyone can become a journalist today with the prevalence of and reliance on the Internet, social media, and blogs. With confidentiality and protecting health information, mental health professionals can take their own initiative to share knowledge or expertise by starting online communities, blogs or regularly contributing to local news media.

Performing a search on a mental health topic and the words "personal stories," yields hundreds of thousands of results and that list is growing daily. With the experience of mental health issues touching such a large portion of the population, we can come to understand the faces and stories associated with mental illness through firsthand accounts. This openness of the very people living and sometimes struggling with mental health issues may yield greater understanding, so that the level of tolerance and inclusiveness can increase.

Voices that are not as prominent in the news media, such as those of minorities, can still be heard or read online. If people make a concerted effort to get to know their stories and bear witness to the uniqueness, beauty, and authenticity of cultural influences, we become aware of the great capacity we human beings possess for healing and resiliency in many areas, including mental health. And it is precisely these stories—both from professional and amateur writers—that may provide the best lesson for mental health professionals. The personal testimonials and journalistic anecdotes are powerful because they tell stories of adversity, triumph, bravery, dedication, love, passion, and heroism. We are all wired to listen to and respond to stories, as academic research has repeatedly shown [88]. In one recent study, researchers at University of Massachusetts Medical School found that patients were more successful at controlling their blood pressure if they heard stories of other people who had succeeded at the same thing—rather than reading a pamphlet telling them the proper steps to take [89]. (The study was later nominated by the Robert Wood Johnson Foundation as one of the 20 most influential research articles of 2011.) Ben S. Gerber, M.D., M.P.H., an associate professor of medicine at the University of Illinois at Chicago, believes stories can help medicine in at least four ways: (1) articles can provide basic information in a more compelling way than a brochure; (2) stories can offer emotional support, showing the patient that they are not the only one with a particular problem; (3) stories can model behavior, such as sticking to an exercise program; and (4) they can help people make decisions about which treatment plan is best for them, by offering a nonmedical view of the pros and cons of a particular approach [88].

Mental health professionals could use storytelling when prescribing treatment, for instance. Particularly for drug regimens that require some tinkering to get right, as with attention deficit hyperactivity disorder, it could make a difference for a patient to hear how a previous patient persisted despite difficulties until they reached an effective and helpful dose. For people with depression who are considering suicide as their only escape from a miserable life, imagine the power of hearing from someone who was once in the same place but is now grateful to still be alive. Telling their stories in a recorded format or others coping with similar problems could also be cathartic for the patient. People with obsessive-compulsive disorder have been shown to improve when they can help others with the condition. Doing something for others and getting out of one's own world can be extremely helpful to people with mental health conditions.

The stories of journalists like Rebecca Skloot, Amy Alexander, and Nellie Bly, as well as the ethical guidance and journalism best practices provided by the Poynter Institute, demonstrate the power of presenting news from a place of courage and integrity. Their willingness to expose critical issues contributed to gradual perceptual shifts in public awareness that had real effects on those living with mental illness, as well as helped tackle serious questions around racial bias and inequality, setting a strong example for other journalists. Journalism has many more opportunities for compassionate coverage that can shine a light in places previously kept dim. The author hopes that mental health professionals may also be willing to contribute their expertise toward greater cultural understanding of mental health through news reporting and by inspiring patients to creatively share their stories in ways that can be healing and empowering for all during these challenging times. As Howard Zinn said, "To be hopeful in bad times is not just foolishly romantic. It is based on the fact that human history is a history not only of cruelty, but also of compassion, sacrifice, courage, kindness.

What we choose to emphasize in this complex history will determine our lives. If we see only the worst, it destroys our capacity to do something. If we remember those times and places–and there are so many–where people have behaved magnificently, this gives us the energy to act, and at least the possibility of sending this spinning top of a world in a different direction.

And if we do act, in however small a way, we don't have to wait for some grand utopian future. The future is an infinite succession of presents, and to live now as we think human beings should live, in defiance of all that is bad around us, is itself a marvelous victory" [90].

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6 Illegal, Alien, and Other: Cultural Competency and Migration

Schuyler W. Henderson

Introduction

Immigration has a unique relationship to the field of mental health: many of the prominent early figures who shaped contemporary mental health were themselves migrants—from the Freuds and Erik Erikson to Eric Kandel and Leo Kanner—and some of the earliest and most important studies that formed the initial evidence base for the practice of mental health, particularly in child psychiatry, involved immigrants. Indeed, immigrants have long been drawn to work in the field of mental health, though often facing prejudice as they do so [30]. All of this is to say that immigration is not simply a demographic characteristic of patients contributing to their psychosocial profile or that can come under the microscope in mental health (as a stressor, as a variable, as a mediator or moderator of outcomes, as a cultural factor to be accounted for): immigration has played a role in shaping what we know about mental health and how we know it.

And yet there is no doubt that immigration remains a hotly controversial political topic. For some years at the end of the last century, it seemed that in the United States and Europe, immigration and migration status was going to play a less prominent political role, while interest in the social (and health-related) consequences of race, gender, and sexuality became more prominent while thinking around these topics became subtler; though immigration has always provoked disagreement and political complaint, it seemed to have settled into something that was often recognized to be a good thing much of the time. Rates of migration and acceptance of refugees into the United States, for example, appeared to be on the rise [27, 40]. Over the past few years, however, immigration has again become one of the most bitterly fought social issues. The United States has been called a "nation of immigrants" (indeed, that was the title of John F. Kennedy's final book [21]), but in the twenty-first century, this same term "nation of immigrants" became increasingly necessary not so much as a reminder of a shared past but as a way of countering increasingly exclusionary and bigoted anti-immigrant rhetoric (as in Barack Obama's address to the nation in 2014 [25]). As the population of the United States became, proportionally, increasingly foreign born, and as migration (particularly from Northern Africa and Turkey) increased in Europe, and alongside the so-called war on terror, Islamophobia, the reality of terrorism, and with the success of increasingly xenophobic politicians (such as the "Americans first" policies

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under President Donald Trump [38]), immigration has again become violently controversial.

Anti-immigrant rhetoric (such as the frequent claim, e.g., that immigration increases the risk of violence, including terrorism and sexual violence) and anti-immigrant policies directly affect people and therefore directly affect clinical encounters [35]. Broadly, anti-immigrant rhetoric and policies depress access to mental health services and increase stressors in immigrant populations, both of which have significant public health effects; more specifically, these pervasive cultural attitudes make conversations around immigration more difficult, even in confidential or supposedly neutral settings.

It is nevertheless important to address immigration when working with any migrant population, and though there may be a shared discomfort in broaching the topic, the responsibility is on the mental health clinician to become more comfortable obtaining an immigration history, allaying or addressing any concerns the immigrant has about safety and security, and ensuring that the immigrant understands the extent to which discussing his or her immigration status is a safe topic.

Safety First

Beyond simply the cultural and political controversies around immigration, there are potential immediate legal consequences to a disclosure of immigration status—whether one's own or the immigration status of another member of the family, such as a parent reporting on a child's status, or a child on an uncle's, for example. These legal consequences for disclosure or discovery of certain immigration statuses (or, to put it more bluntly, being officially identified as "illegal") may include family separation, detention and deportation. This means that in addition to personal sensitivity around the subject, clinicians need to disclose whether they are able to keep information around immigration status confidential.

At the hospital where I work, immigration status is not formally obtained and those without current legal immigrant status will not be reported; this is not a universal rule in health care settings, and practitioners should know their setting's rules on this and, if necessary, disclose them before obtaining information that could put their client/patient in jeopardy.

The National Immigration Law Center has provided a useful guide for practitioners offering advice (which they acknowledge cannot constitute legal advice) on how to address immigration officials and officers who may attempt to enforce immigration laws in a health center, including ensuring that patient information is protected or not accidentally disclosed [24].

Clear policies that are visible, legible, and understood by all the practitioners and support staff in any clinical setting are required so that someone accessing mental health care will know what they can or cannot disclose as they seek care.

Models of Migration

While migration status is often categorized by legality (such as determining if someone is an "illegal alien"), and while this legality may be the most significant factor—and stressor—in terms of a migrant's current mental status and psychological safety, legality itself says little about the process of, and rationale for, migration.

Voluntary and Involuntary

Migration is often viewed as either voluntary or involuntary (forced) migration. Voluntary migration typically involves economic or employment-related migration, from the vast number of agricultural workers (thought to number in the millions of migratory farm workers in the United States [23]) or construction workers who travel across national lines to build skyscrapers and homes, to the expertise-related migration of engineers and physicians or graduate students. Family reunion is another voluntary reason for migration, as families come together around employed family members (sometimes disparagingly referred to as "chain migration," even by people who themselves have this "chain migration" in their own history).

Involuntary or forced migration refers to people who are forced to leave their country of origin due to violence, persecution, fear of persecution, or environmental disasters. One such population is the "refugee," defined legally as someone who:

> owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. [39]

Although "refugee" is a well-recognized legal status, people who have fled their country of origin may not have qualified for the designation because of political decisions made on a global scale or decisions made by immigration officers when they are seeking asylum.

But the distinction between voluntary and involuntary migration is not always clear cut. Of course, there are multiple reasons for migration, and "voluntary" migration may not be voluntary insofar as economic disadvantage, global inequity, and social injustice may drive people to work in another country (where they are frequently vulnerable and exploited), and the quest for "refugee" status is denied to many who are fleeing persecution.

Push and Pull Factors

In discussing the rationale for migration with someone, the focus should be less around a single motivation, and rather an attempt to understand the diverse factors that cause someone to move from one place to another. One way to think about this is in terms of "push" and "pull" factors: the factors pushing someone away from a country of origin and pulling them into a new country. These push factors can be obvious (such as unemployment rates, persecution, poverty) or subtle and personal (such as getting away from obnoxious relatives), and similarly the pull factors can be clear (coming to a job at a university, to reunite with a partner) or difficult to express (dreams of a better life, a desire for something new).

It is worth remembering that even within a single family, there may be different legal statuses, and certainly different narratives about reasons for migration, as well as different push and pull factors. One refugee family in the 1990s demonstrated this when the teenage children, for example, were thrilled to be in Chicago for the music scene while the parents were profoundly distressed by their inability to find work commensurate with their skills in their native Bosnia, though all had fled Bosnia together and all could similarly describe the atrocities they had witnessed and the fears they felt.

The Tripartite Model

In discussing models of migration, another way to conceptualize migration other than legal status and through understanding the rationale for migration is to look at the different phases of migration; an advantage of considering this model is that in this tripartite model, there are different associated psychosocial stressors, which can be usefully elucidated.

The first phase is "pre-migration," the period before migration. The stressors are often ones precipitating departure, including poverty, famine, environmental disasters, war, systematic persecution, and other systematic violence, such as gangs, political oppression, and domestic violence [28]. These stressors can directly impact children's and families' development, disrupting employment and education, resulting in physical danger, somatic and psychiatric morbidity, and in stressing family relations.

The second phase is "migration," the movement itself. The stressors here include psychological stressors (loss of a homeland, exposure to dangerous situations, uncertainty) as well as the dangers inherent in migration (exploitation, exposure to human trafficking, victimization) and family separation, as when children are not accompanied by parents or when they are forcibly removed from their parents [7, 13]. For example, Suárez-Orozco et al. reported that 85% of adolescents from Central America, China, the Dominican Republic, Haiti, and Mexico had been separated from parents for extended periods and that this separation was associated with subsequent depression in these youth [33].

The third phase is "post-migration," which follows the arrival in the destination country. Stressors here include the nature of the arrival (whether there has been detention, e.g., or forced family separation), as well as the challenges of re-settling in a new environment, such as learning a new language, negotiating new cultural expectations, exposure to stigma, the effect of policies and cultural attitudes around migration, and accessing necessary systems, including educational and health care systems [4, 37].

Acknowledging the Journey

If a discussion about migration status can safely proceed, there are a multitude of ways of talking about migration and a multitude of frameworks for understanding the journey and its effects. Throughout this chapter, in the hopes of covering clinically relevant issues that arise around migration, one of the key points is that stories about migration will unfold like any narrative: they will be personal, complicated, consistent with some expectations and inconsistent with others.

One way to begin understanding the role of migration is to obtain a migration history.

The reasons for obtaining a migration history include:

- *Understanding the person*: Migration is usually a very significant event in a person's life, rarely indulged in frivolously, often involving both resilience and loss, and can be a centrally important feature in a person's life. Leaving one's home is almost universally a normative developmental experience; leaving one's homeland typically involves difficult decisions and, even when forced, some degree of intent.
- *Understanding relationships*: Migration shapes who one lives with and who one does not (e.g., whether a child is with parents or a child has been left behind with grandparents); a migration narrative typically entails separations, some of which are tremendously stressful, but may also involve important reunions (which can be stressful: I knew one child whose mother had come from a Central American country to join her 8 years after the girl had left that country, and the mother and daughter had both typical joys and complaints about one another, but had to negotiate a very complicated relationship around limit-setting, with a child unused to a mother who was now setting rules for her).
- *Identifying strengths*: If one thinks about how difficult it can be to move from one apartment to another, one may have increased sympathy for the immense strength it takes to move from one country to another. Rare is the migration story that does not in some way highlight a person's resilience, courage, and capacity to survive.
- *Identifying potential cultural differences*: The migration story not only explains an event and how a person is connected to, or not connected to, family members and communities, but it will begin to give the listener an insight into potential cultural challenges in language, resources, expectations, and experiences.
- *Identifying potentially relevant recent or distant stressors*: While migration stories may be positive and clear (as when someone makes a decision to move for educational reasons, obtains a visa, and comfortably re-locates), others may involve more complicated experiences or frank trauma, even multiple episodes of trauma.
- *Identifying current stressors*: Past trauma before or during migration is important to elicit, but current stressors, including ones related to education, employment, and family, can be the most closely correlated with current mental health. Practically speaking, although past events may be more horrifying, current stressors may be the ones that are most pressing and need to be addressed first.

Treatment planning: The migration story can certainly include a psychiatric history of treatment (such as having had treatment in one's home country), but can also be important to allow for a fuller discussion of ongoing migration plans, such as plans for moving on to a different city or even different country.

As when telling any personal history, someone's telling of their stories will be shaped by trust, expectation, and relevance—and given the controversy around migration and "legality," this sensitive topic may not be wholly disclosed during an initial encounter. In order to elicit a migration history, you can consider asking about:

- *The journey (where they originated, where they moved to, how they arrived, where they are now)*: Where did you come from? Did you come directly here? How did you leave? Where did you stay along the way?
- *Reasons for migration*: When did you start thinking about leaving? What were some of the reasons for moving? What ultimately made you decide to move? When did you know you were going to leave?
- *The extent to which it was voluntary or forced*: Did you have a choice about where you were coming? Did you want to come here?
- *Whether the journey is understood to be complete (for example, whether a return to the native country is anticipated or further movement for employment, family reunification)*: Do you plan to return? Do you hope to return? Do you want to stay here or do you see yourself moving on?

Challenges to Assumptions

In thinking about cultural competency in relation to immigration and obtaining a migration history, there are a number of assumptions about migrant communities that should be addressed.

The Permanence and Totality of Migration

Migration may not be forever: although this may be more obvious with migrants whose jobs entail frequent travel (such as agricultural workers), it is also true that a migration narrative may include plans to return to a country of origin or to move on to other countries. Furthermore, the connections with the home country should be considered: this includes what sort of connections are being maintained and lost, what sort of contact people are having (especially in this era of widespread electronic connectivity), and what sort of roles and responsibilities are being maintained (such as when someone is making money to send to family back in their country of origin).

Home

"Home" defines and shapes and creates who we are, through our relationships, the extent to which we do or do not belong, the things we are familiar with, and the ones that seem to come from outside; home is where we learn languages, cultures, and rituals which come from the larger world but are inflected, shaped, and experienced in a private way. When one answers questions about where one is from, the answer is always a variant on "home." As described by Henderson, Sung and Baily [18]: "Migration complicates and challenges simplified notions of home. With migration, we may have multiple homes, multiple places we come from, multiple cultures and societies in our backgrounds, shifting and changing and developing and intermingling. As such, migration can have a vast array of meanings—legal, psychological, and psychopathological."

Being open to this plurality of meanings without necessarily being fixed to assumptions is the most generous and productive stance when listening to people talk about their home. At the same time, it is necessary to remember that the question "Where is 'home' for you?" may well have the answer, "Here." Whether welcomed or not, migrants will to some extent have adapted and absorbed some of the customs and traditions of the society they are now in—a society inevitably influenced and shaped by countless prior migrations.

Diversity Within Diversity

It is extremely important to remember that there can be immense diversity between, and within, migrant populations and that migrant status and country of origin are only broad indicators of demographic and cultural orientation. Indeed, within migrant populations, ethnic and socioeconomic status can be highly variable [1]. For example, although a population may qualify as "refugees," even within that population there will be multiple individual reasons for migration (push and pull factors), and these may differ within communities or families, as can legal statuses (there was a child in our program whose uncle was deported when caught by immigration services; she herself was not under threat of deportation as a citizen).

And of course, within migrant populations, there will be diverse educations, diverse pre-migration and post-migration employment experiences, and diverse experiences of persecution and safety (e.g., someone who has migrated for the "economic" reason of obtaining high-tech employment in Silicon Valley but was also a victim of gender-based violence).

Language

Similarly, in addition to being cautious about cultural assumptions based on country of origin, so caution must be exercised when assuming that because someone is from a particular part of the world, they speak the dominant language there. In a New York City clinic, some of the Central American and Mexican migrants do not speak Spanish as a first language, and this also happened when children separated by Trump, Sessions, and Nielsen from their parents at the border were placed into detention centers or with agencies who had Spanish speakers but nobody who could speak local dialects and hence were unable to communicate with the children. It is then important to assess what languages are spoken by each person, which languages are spoken in the home (can the children, e.g., understand their parents?), and levels of fluency and competency in the language(s) of the host country.

There are a number of issues that arise around language, particularly in migrant families: the extent to which the children and parents share (or do not share) language skills and fluency can result in conflict. When members of the family are not fluent, it is well-established that an interpreter should be used, without assuming that the more fluent members can or should interpret in place of a professional interpreter.

Once again, language is an issue that can and should be specifically addressed. When meeting one or more members of a family, it is important to identify these generational differences. Can, for example, a grandparent function effectively outside of his or her language community? Or, as another example, can both parents attend parent-child conferences and understand the teachers? Which adults can decipher report cards or help the child prepare for college?

Without trying to marginalize or belittle the migrants' language skills, it can be important to not just identify language competency in the host nation's language(s) but barriers to learning that language, including cost, availability of tutors, willingness/ability to learn a new language. Being unable to speak a dominant language can result in isolation, marginalization, and ensuing social difficulties (including communicating with officials, obtaining appropriate papers, etc.). While it can be important and culturally valuable for children to learn the language of their parents and losing use of one's original language may be a risk factor for psychopathology [9], competence in the language of the country the children are living in has been shown to predict social functioning as well as academic performance [36].

Stigma

Who are we meeting when we encounter "migrants"? Given that the term is not all-inclusive or all-explanatory, one should nevertheless be aware not just of how migrants are lumped together, but how the concepts and language of lumping have effects. The language one chooses is itself important and can import assumptions that are clinically relevant. In 1 study of 247 mental health professionals across 32 states in the United States, the term "undocumented immigrant" resulted in viewing vignettes more positively than "illegal alien" [3]. The language used to describe populations—including "illegal" and "alien"—can be profoundly marginalizing.

This can produce stigma. Stigma has been defined by Goffman as a "deeply discrediting" attribute that reduces the bearer "from a whole and usual person to a tainted, discounted one" [16]. Without a doubt, stigma is attached to migration and migrants as bearers of disease, as leeches and parasites on the economy, even though migrants benefit the economy [14], or as criminals, even though they do not disproportionately contribute to criminality [17].

Stigma, of course, operates within migrant communities as well, and there have been claims that there is a higher prevalence of stigma around physical and mental health in immigrant populations [10, 12, 26] which results in suboptimal care [20, 43]. However, this is not necessarily true or at least universally true (as when Nadeem et al. show that immigrant Latinas were most likely to want mental health care and were among the most likely to report stigma [22]), and it can be a lazy assumption when much more subtle barriers are present, which are being called "stigma" (e.g., the refusal to see a psychiatrist may not be "stigma" per se but a lack of clarity about the role of this new physician).

Pathology

In terms of addressing mental health, there are longstanding debates in the literature about the relationship of migration to mental health, with a substantial number of studies suggesting lower rates of mental illness in migrant populations, where migrants are doing better than native-born populations. The current evidence suggests that while immigrants tend to have lower rates of mental illness in general, there is worsening mental health in later generations [34, 42]. US studies that focus on anxiety, mood, and substance disorders, for example, suggest that immigrants tend to do better than native populations but then the second and third generations catch up [8]

Of course, there are a number of risk and resilience factors, as well as cultural ones, that influence these epidemiological findings. Successful migration may be a function of resilience but also increases exposures to risks; there may be nosologic variations (how psychological distress and psychiatric illness presents) that make the presentation of psychological suffering more apparent to local cultures in more-assimilated later generations, which may also be described as nosologic visibility (as migrants acculturate, the presentations become more apparent and culturally congruent with those of the host country).

Sensitivity to the way in which mental illness is conceived is of course necessary. Behaviors that may not seem normative or pathological in one country (particularly around psychoses, hallucinations, ideas of references, visions, etc.) may not be conceived in the same way in another—and certainly some behaviors may be considered pathological by migrant parents but normative in their new country (such as with some forms of teen rebellion or sexual or gender expression).

While it is important to get a sense of understanding the cultural context for any diagnosis or symptoms, cultural competency with migrant populations includes not forgetting the basics, such as investigating how the person believes symptom onset is or is not linked to psychosocial stressors, ascertaining normative expectations around stressors, and being open to normative, cultural, and familial understandings of what is happening, as well as providing supportive psychoeducation.

Understanding cultural beliefs around health, illness, and treatment, and what resources are being used in the community (including remedies, medications, herbs, etc.) remains important, but, as with all such discussions, should not lead to closure or assumption, such as assuming that there is an opposition between "traditional" services and host nation treatment options. In one study, for example, in Cambodian refugees in the United States, use of alternative and complementary medicine was positively associated with an increased use of "Western" providers [6].

Parenting

Migration is a family affair, and whether the clinician is encountering a child, a middle-aged migrant, or a geriatric migrant, a family history should be obtained to understand who they are living with, and in considering cultural competency around migration, one has to be sensitive to family constructs and expectations. One of the key challenges for migrants in their families is around parenting.

Parenting is a function of cultural, social, and biological imperatives, in which the parent not only provides such basic needs as love, nutrition, shelter, and guidance, but introduces and instills language, values, cultural norms, and beliefs, all of which have their own origins in earlier homes, places, and societies; and yet, of course, as the expression goes, it takes a village to raise a child, and children have their basic and developmental needs met by more than just their parents, learning from peers and other adults around them. For a migrant parent, this will almost certainly mean greater exposure to host country youth culture for their children. While such a statement is hardly controversial, and while it is recognized that there are intense social and political pressures that arise with migration and that affect parenting, this simple observation opens up generational schisms that, while they always exist, can be specific to migrant families. Not to put too fine a point on it: children are socially and culturally different from their parents, and these differences can be magnified by migration [41].

The consequences of this for mental health can be enormous and require sensitivity to differences, without necessarily assuming what those differences are. For example, the assumption that an immigrant parent's values are necessarily the same as those that are assumed to derive from their point of origin can be a mistake (e.g., one might assume that the parent would believe in the same gender roles commonly thought to be prevalent in his or her country of origin, when in fact that parent left the country of origin in part because of those roles).

Furthermore, as psychiatrist (and immigrant), Salman Akhtar, points out, the parents' own experiences of migration lie across these generational tensions: *immigrant parents are too overworked, tired, and struggling with their own psychosocial turmoil to the extent that they cannot pay attention to their child's distress…the early experiences of biculturalism become traumatic and intensify ordinary developmental conflicts, setting up a vicious circle whereby problems at school and problems at home begin to compound each other* [2].

When it comes to parenting, once again, one must remember the basics: what stresses parents and children across the globe are very similar: youth want to grow up and be independent; parents worry about safety and values. Generational factors that may influence mental health in children and families include cultural and personal beliefs around success, about parental "sacrifice" on behalf of their children, educational expectations in the household, as well as the multitude of beliefs around socialization, especially regarding sexual and gender identity development, that almost universally can create conflict in homes but may be more pronounced in immigrant households [32].

In order to elucidate the potential conflicts in the family, and to get to understand what the parents are experiencing, the clinician can ask open-ended questions about how the parents themselves were raised, how they want to raise their own children, what sort of differences they see between their own parenting and parenting in non-migrant communities they live among, and what expectations they have for behavior, roles, and future goals for their children (and how these might be different from their country of origin).

It is often, although by no means always true, that children assimilate more rapidly into the host country, which can result in "acculturative family distancing" (acculturative gaps between generations), which in turn can create stress, as well as potentially different expressions of symptomology in mental health, reducing the ability of generations to understand each other's psychological suffering [19].

These concerns can also be addressed with open-ended questions about hopes and concerns the parent might have (about how the child is adapting to the new culture, how it is affecting their relationship, about how they would like their children to be connected—or not—to the parent's country of origin, and what sort of practices and beliefs from the home country). It is important not to avoid issues that are commonly found in generational conflicts and directly relating these to questions about the parents' own experiences and history, such as around gender roles, romantic relationships, and expectations around autonomy, and schooling/employment.

In addition, beliefs around parenting may clash with local beliefs—as may happen with corporal punishment. This can result not only in stress within the home but may result in severe legal consequences. Assessing for how children are punished and providing culturally sound guidance on how to deliver rewards and consequences may prevent severe legal consequences or removal from the home.

What Do We Expect?

There is often intense political debate around how migrants should adapt to their host country with frank and often dissonant expectations for migrants. These conflicts can also play out within migrant communities. Three common models conceptualize this process of adaptation and speak to the challenges faced by migrants.

Assimilation, one model for adaptation, has been defined as the process by which "the culture of origin is rejected and the host culture largely adopted, with the loss of language and customs of origin" [29], whereas acculturation, a second model, is a process of immersing oneself into the host country without the full loss of language and customs, often with a goal of "biculturality" in which the person remains part of one's culture of origin but can function in and participate in the host culture. Of course, this cannot be easily distinguished from political and ideological assimilation or acculturation.

Other models include "fusion" (in which cultures blend to form a third, new culture) and multiculturalism, in which there is a co-existence and sharing of cultures without the loss of any particular culture [11]. One author describes a naturalization ceremony where new immigrants are becoming US citizens, which touches on all these models, and how the woman presiding over the ceremony said that the new citizens "should speak English whenever they could, take part in elections and otherwise fulfill their civic responsibilities, but she also told them they should feel free to continue speaking their native language, celebrate their own cultural backgrounds, and stay true to their religions" [15].

While there are many possible ways in which any cross-cultural encounter can take place, migrants will negotiate these tensions between exclusion and assimilation, alienation and acculturation, and the extent to which they can engage in biculturality on a personal level; within families, however, there may be different ways of resolving these tensions, including across generations [44, 45]. The clinician must not only be attuned to these differences, but aware that bicultural stress may affect generations differently, as well as having different impacts on mental health [31]. In addition to assessing integration, assimilation, and biculturalism, there may also be those who find they fit in nowhere. In 1 study of over 3000 adult second-generation immigrants in Canada, Berry and Hoo identified a "marginalized" population who had a weak sense of belonging both to Canada and their ethnic group [5].

Loving the Alien

Cultural competency in addressing the issue of immigration requires an awareness that anti-immigrant sentiment and anti-immigrant policies will affect how, when, and why immigrants will access and make use of mental health services; a comprehensive approach to cultural competency beyond sensitivity in the individual encounter is ensuring that the space and environment is safe and supportive, from having appropriate translation and interpretation services to sensitivity around how and when documentation of any nature is requested (including personal identification).

Being open to listening to migrant experiences, understanding how they may differ from person to person and within families, and even change over time, is the first step to appreciating the extraordinary, and yet common, experience of leaving one's home and coming to a new land. Most relevantly for the purposes of clinical practice, this openness and interest begins the most important therapeutic process of all: welcome.

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Part II

Specific Populations

7

Psychiatry for People of African Descent in the USA

Carl Bell and Christine M. Crawford

Introduction

People of African Descent (PAD) in the USA are comprised of both African Americans—many of whom have marched a rough terrain, from roots in Africa to crossing the ocean to the USA, experiencing enslavement and for some, to present-day mass incarceration—and more recent African and Caribbean immigrants. For some African Americans, the path through American slavery has led many to exposure of significant collective and personal trauma that deeply influences their mental and physical health. For other PAD who had voluntarily immigrated to the USA, the path has been one of historical colonialism, national independence, and recent immigration. In order to effectively treat and even prevent mental disorders in PAD, it is important to know and appreciate the history, context, and dynamics that influence this diverse group of people. Without this knowledge and subsequent deliberate responses, the mental and emotional strife that some PAD face will persist. This chapter provides a description of the history, context, and dynamics that influence the mental health and wellness of PAD in the USA. The authors also identify and delineate treatment needs, suggest ways to address these needs, delineate gaps within the system, and provide recommendations for next steps. Ideally, after reading this chapter, readers will have taken one step forward along their path to better the mental health treatment of African Americans and have an idea of directions for future learning and growth. Unfortunately, our information about the recent PAD immigrants is just beginning to be unearthed, so we will need to be patient until we can speak more confidentially about these populations' issues.

Who Are People of African Descent in the USA?

In the USA, PAD constitute approximately 13% of the population with over 42 million people [1]. Who these people are is a complex question with a multilayered, multifarious answer. This question can be answered on various levels—from history and collective experiences to behavioral characteristics, values, norms, and demographics. On the surface, the whole of PAD is defined in the title—those who have roots in Africa who live in the USA. However, identity goes much deeper than the location of a person's or group's roots. Although PAD have ancestry from the

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same continent, the cultures and ethnicities on this land mass are quite varied. In addition, coming from Africa, people of the African Diaspora were taken to various parts of the world, including countries ranging from Haiti to Brazil to the USA. Africans were sold directly from African countries, particularly West Africa, and taken to the USA to be used and/or sold again. Progeny who stayed in the USA are now typically categorized as African Americans. However, over the years, the variety within PAD has increased with the immigration of Blacks from the Caribbean, South America, and directly from Africa. Over 91% of PAD are native born Americans; 9.1% are immigrants; 4.9% of those are naturalized citizens, and 4.1% are not yet a citizen of the USA [1]. Additionally, Africans had the fastest growing segment of the black immigrant population in the USA, increasing by 137% from 2000 to 2013. Approximately 28% of African immigrants came to the USA as refugees [2]. Thus, there are multiple histories, contexts, and cultures within this group. Whether bought and sold by the USA, British, or French, slavery occurred in the Caribbean, Europe, USA, and other places. However, the vitriolic nature of the slavery was different from place to place. Thus, a great majority of PAD have connections to US enslavement and have experienced collective and historic trauma. Throughout this chapter, the authors go deeper into the aforementioned layers of the identity and culture of PAD, but will focus on the majority of PAD—African Americans. This chapter also includes the mental health repercussions (and even deliberate consequences) of some of these collective and historical experiences.

History As It Relates to Mental Health

From enslavement to the present day “post-racial” society, African Americans have had a tumultuous past relationship with health services in the USA. Hence, it has led many to have a mistrust of health services, including mental health. During times of enslavement, diagnosis was used to manipulate and control those who were enslaved. For example, in 1851, Samuel A. Cartwright proposed two slave-specific disorders: drapetomania and dysaesthesia aethiopica. Drapetomania was deemed a “disorder” characterized by slaves running away and seeking freedom. Cartwright proclaimed that equal treatment was the cause and enforcing submissiveness was treatment. In order to prevent the disorder, owners were prescribed to treat the enslaved like children [3]. Laziness characterized dysaesthesia aethiopica, which was supposedly related to skin insensitivity. Thus, treatment included stimulating the skin by washing, covering it with oil, slapping it with a leather strap, and working in the sun [3]. Enslaved individuals were not only used as “workhorses,” but physicians bought and also used them as participants in dangerous medical experiments that were seen as not safe enough for European Americans. In surgeries, the enslaved were deprived of anesthesia and were often given subpar medical treatment. Following slavery, medical (both physical and mental) injustices persisted, such as the deprivation of proper psychological treatment for African Americans. Historically, there were few psychiatric facilities that treated African Americans with legitimate mental illnesses [4].

In the decades following African enslavement, governmental institutions such as public health services and schools and public policies have left these communities disproportionately poor [5] and unhealthy [6]. As in the other sectors of the USA, in mental health, African Americans were seen as inferior to European Americans and, thus, much of their research and diagnoses were tainted by confirmatory bias and reflected this notion. Eugenics and similar research, ideology, and general ethnocentric monoculturalism [7] reigned and were perceived as truth [8]. Thus, psychiatrists and psychologists viewed African Americans unable to experience “sophisticated” disorders that required some abstract thought, such as depression [9]. Thinking such as this has contributed to significant, generational misdiagnosis, leading to mistreatment and poor prognoses. In the area of public health services, the Tuskegee experiment is one example of a quintessential ethical crime that left African Americans distrustful of the system. Beginning in 1932, the US Public Health Service (PHS) in Alabama began an investigation of how syphilis influenced the physiology of the body, particularly among African American men. While their participants were alive, their study was mere observation, watching the progression of the disease until death. Once they died, the physicians performed autopsies to better study the bacteria. "… These men were regarded by an impatient PHS as living cadavers, more valuable to American medicine as dead than alive" [4]. Although their study was disguised as treatment, PHS's intentions were never to provide treatment but to catalogue the dying process and dissect at death. In their recruitment of participants, they "offered" treatment. Throughout the study, they pretended to provide treatment, giving vitamins and insufficient doses of medication. Even when penicillin was introduced as an "effective drug" for syphilis, the physicians continued their study and their deception. The study was maintained despite the availability of treatment until 1972. Over the course of this study, over 100 African American men died, 40 of their wives contracted the disease, and nearly 20 children were infected at birth [4]. Hence, there is, for some, still a transferred, generational, and disproportionate mistrust of the healthcare system.

After the 1970s and with the more significant shifts due to the civil rights movement, healthcare, including mental health, opened up to African Americans. However, as overt racism did not align with American ideals, more subtle forms of racism began to manifest. In seminal research, Dr. Pierce [10] started to identify more subtle racial dynamics, such as microinsults and microaggressions, which continue today [11]. In the 1980s, this nation entered the era of cultural sensitivity, with calls for more social workers, physicians, psychologists, nurses, and psychiatrists of Color [12] and a greater focus on diversity issues. Also during this time, misdiagnoses of African Americans were identified as a major problem [13, 14], which also continues today [15]. Thus, some of the numbers around prevalence are thought to be inaccurate [16]. Today, due to the mistrust, mistreatment, stigma [4, 16], and lack of access [6], African Americans use mental health services less than European Americans.

Prevalence and Utilization

African Americans face many issues that negatively affect their mental health and general well-being, including disproportionate amounts of poverty, low-quality education [17], racism [18], being unfairly targeted by the criminal justice system [19], and cloistered in ghettos [20]. Paradoxically, most rates of mental disorders and mental illness in African Americans are less or equal to European Americans. Although it has been well documented that suicide rates are generally higher for European Americans when compared to Africans Americans, recent data demonstrated an increase in the rates of suicide in African American children aged 5–12 years. During 2001 through 2015, African Americans aged 5–17 years had a 42% lower rate of suicide than European American youths. However, when the data was stratified for age, African American suicide rates in this age group during this time period went up from 1.36 per million to 2.54 per million compared to 1.14 per million to 0.77 in European American children [21]. Although this finding suggests that African American children younger than 13 had a two times higher rate of suicide when compared to European American children, the clinical significance is currently up for debate given the small difference between 1.36/1,000,000 compared to 2.54/1,000,000,00 [22].

For African Americans over 50 years of age, 8.8% reported an episode of major depressive disorder (MDD) in their lifetime and 4% in the last 12 months. For older Black Caribbeans, 11.2% reported MDD in their lifetime and 8.2% in the last 12 months [23]. In this case, Black Caribbeans had a higher prevalence rate than White Americans (5.9%) of MDD in the last 12 months. Outside of that, older White Americans had higher rates of MDD [23]. Such is the case for most other mental illnesses (see Table 7.1), except for more stigmatizing disorders like psychotic disorders and personality disorders [24].

Table 7.1 Mental illness in PAD

Mental illness[a]	African Americans (%)	Caribbean Americans (%)	European Americans (%)
12-month prevalence of any mood disorder	7.75	4.82	8.63
12-month prevalence of any major depressive disorder (MAD)	4.58	2.22	5.53
Lifetime suicide ideation and attempts[b]			
Ideation	11.7	12.3	
Attempt	4	5.1	
12-month prevalence of any anxiety disorder	10.72	6.22	11.70
12-month prevalence of any substance use disorders (SUDs)	16.63	4.56	20.44
12-month prevalence of any psychotic disorder	0.58	0.61	0.32
12-month prevalence of any personality disorder	16.67	16.79	14.65
Lifetime prevalence of conduct disorder	1.05	0.97	0.99
Lifetime prevalence of any disorder			
Axis I	43.4	24	55.4
Axis II	16.8	16.7	14.7
12-month prevalence of any Axis I disorder	28.1	14.5	31.5

[a] All data except on suicide is from Gibbs et al. [24]
[b] Data from Joe et al. [25]

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are exposures in childhood (prior to age 18 years old) that are deeply distressing or disturbing. Felitti and Anda [26] have conducted studies assessing the number of people's ACEs (ACE score) and their correlation to health-related problems in adulthood. They found that the higher number of ACEs, the more likely the person is to experience later morbidity, such as cardiovascular disease, diabetes, substance use disorders (SUDs), cancers, and sexually transmitted diseases. Those with 4 or more ACEs were 7.4 times more likely to abuse alcohol, 10.3 times more likely to abuse drugs, 4.6 times more likely to have depression, 12 times more likely to have SA, 2.2 times more likely to be a smoker, and 3.2 times more likely to have over 50 sexual intercourse partners than people with zero ACEs. Those with 4 or more ACES were 2.2 times more likely to have ischemic heart disease, 1.9 times more likely to have cancer, 3.9 times more likely to have chronic lung disease (bronchitis and emphysema), 1.6 times more likely to have skeletal fractures, 2.4 times more likely to have liver disease, 2.5 times more likely to have a sexually transmitted disease, 2.4 times more likely to suffer from a stroke, 1.6 times more likely to have diabetes, and 1.6 times more likely to struggle with severe obesity than those patients with zero ACEs [27]. In their studies with the Center for Disease Control and Prevention [28], they found ACE disparities by race and SES. There was an inverse relationship with SES and ACE score. Ironically (given the disparities in education and income level) [17], compared to Whites and Hispanics, African Americans have the lowest percentage of those who had experienced five or more ACEs. However, they are more likely than Whites to have four ACES, and they have the highest prevalence of family fracture (parental separation/divorce) and having a household member in prison [28]. Other confounding variables include the fact that there is a disproportionate representation of African Americans in special education, foster care, and the criminal justice system. Combined, these facts make the depiction of African American people and their ACE score seem incomplete. One fact that may complete the picture is what is constituted as trauma. The ACE assessment does not include racism, witnessing violence in the community, or being unfairly targeted by the criminal justice system [29].

Factors Contributing to the Paradoxical Prevalence Rates

There is apparent irony when examining the prevalence rates of mental disorders and the predicament of many African Americans and some possible reasons that may explain this seeming paradox. Harken back to the history of not thinking that African Americans were sophisticated enough to have a mood disorder [9] and the use of diagnoses to maintain status quo. Such could explain the higher rates of psychotic disorders (*or diagnoses should we say*) and lower rates of mood disorders. Furthermore, the paradox of historic and collective hardship and lower rates of general mental disorders can also be understood within the context of a lack of cultural sensitivity and knowledge and, thus, misdiagnosis. Culture-bound syndromes and certain culturally specific idioms of distress, expounded on later in this chapter, could convolute psychological case conceptualization and lead to misdiagnosis. If mental health professionals are not aware of certain symptoms within culture-bound syndrome categories, they may diagnose it as something else [30] or may not diagnose it at all. Furthermore, African Americans suffering from ailments may distrust the system or professional and choose not to disclose their experience. If they do disclose some type of psychiatric-related symptom, it may be more likely that they disclose a physical or somatic symptom. Hunter and Schmidt [16] suggest that some of the physical symptoms African Americans disclose, usually going along with cardiovascular disease, diabetes, and hypertension, are actually “somatizations” of anxiety. Jackson et al. [31] propose that the physical symptoms are a result of what Wright [32] calls “soft addictions.” Soft addictions are distractions or ill methods used to escape our more challenging emotions and directly addressing our pain, including activities like watching television and eating junk food. Jackson and his colleagues [31] convey that many PAD, especially in low-income communities, may be eating their pain, drinking away their sorrow, and engaging in sex to escape their stress. Thus, we see the tremendous historic and present stressors, the lower rates of diagnosed mental disorders, and high rates of physical illness (e.g., cardiovascular disease and diabetes). Another explanation for the lower rates of diagnosed mental disorders is the finding that African Americans do better when assessed with measures of flourishing [32]. This discovery may indicate that many African Americans may have significant resilience and protective factors buffering them against the some of the ill effects of hardship.

Utilization

Another possible explanation for this seeming contradiction is the rate of mental health services utilization. Across the board, African Americans use mental health services less than Whites. According to data from the National Comorbidity Survey–Adolescent Supplement, Costello and colleagues [33] found that African Americans adolescents ages 13–17 years old were significantly less likely than their White counterparts to utilize specialty mental health or general medical services for mental health disorders.

For college students, Hunt et al. [34] identified significant mental healthcare disparities between Whites and their minority counterparts despite having access to mental health services on their respective college campuses. According to data on college aged adults between 18 to 25 years old from the National Survey on Drug Use and Health [35], 14.1% of Whites used mental health services in the past year compared with 6.5% of African Americans, 5.7% of Asians, and 6.7% of Hispanics.

This disparity in mental healthcare utilization persists all throughout adulthood. Adults of two or more races are more likely to utilize mental health services when compared to Whites and African Americans. Approximately 17.1% of adults of two or more races accessed mental health services between 2008 and 2012 versus 16.6% of White adults and 8.6% of African Americans [35].

Additionally data have demonstrated stark differences among those of different ethnic backgrounds in the rate of prescription drug use for those with a psychiatric condition. Prescription drug use was the highest among Whites with 14.4%, American Indian/Alaska Native 13.6%, and African Americans 6.5%. In regard to seeking out care in an outpatient setting, only 4.7% of African Americans received care in an outpatient setting between 2008 and 2012 compared to 7.8% of Whites [35].

Numerous factors contributing to the disparities in mental healthcare utilization have been studied by various researchers; however, the religious beliefs of some African Americans have been found to influence the likelihood of receiving formal mental healthcare [36]. Historically, African Americans have high levels of religiosity and typically seek out guidance on mental health-related issues from clergy as opposed to formal mental health specialists [36]. Lukachko and her colleagues found an inverse relationship between church attendance and the use of formal mental health specialists. She found that African Americans who reported a high degree of religiosity were less likely to utilize mental health professionals when compared to African Americans with low levels of religiosity [36].

Idioms of Distress

A lack of mental health service utilization may perpetuate problems, such as idioms of distress. Idioms of distress are ways that people cope, be it constructive or destructive, with their pain or struggle. They are alternatives in the expression of psychosocial distress and are often shaped by situational sociological circumstances. Accordingly, idioms of distress vary between social classes. Thus, in addressing idioms, it is important for mental health providers to be aware of how demographic factors, like social class, influence the idioms.

A common idiom of distress found in low-income African Americans is substance use disorders (SUDs). Fullilove et al. [37, 38] provide evidence of this by noting a substantial percent of low-income African American women addicted to cocaine in New York City had been sexually assaulted before they began abusing drugs. Related to the notion that SUDs are an idiom of distress in low-income African American men, Bell et al. [39] identified a phenomenon of chronic alcoholic hallucinosis. These patients had extensive work histories and sophisticated interpersonal skills, but reported hallucinations, insomnia, and paranoid ideation without psychosocial deterioration. Furthermore, these patients did not develop their psychotic symptoms until they were mid- or late-life adults after an extensive history of chronic substance abuse. Alcohol consumption is often a “poor person’s vacation.” Unfortunately, it can be fatal if abused chronically, as cirrhosis was identified as one of the six causes of excess deaths in African Americans [40]. Social drinking by African American women who are unaware they are pregnant is also responsible for the high rates of fetal alcohol spectrum disorders in African Americans [41].

Another common idiom of distress in PAD is spiritual pursuit. The use of religion is a mainstay of PAD’s quest to respond to stress, distress, and traumatic stress in a healthy manner [42, 43]. The research is clear that PAD who are experiencing serious distress are particularly prone to use religious coping strategies and more likely to seek help from a minister than other helping professions [44].

Culture-Bound Syndromes in PAD

Culture-bound syndromes, unlike idioms of distress, are directly connected to rich indigenous traditions and are not necessarily a choice. They are indigenous traditional ways for various cultural, racial, and ethnic groups to express psychological distress and other forms of emotion [2, 45]. Researchers have demonstrated that the symptoms reported in anthropological literature resemble those of certain established mental disorders, and that they often warrant and are linked to seeking assistance among African Americans [46].

Acute hallucinatory phenomena known as “bouffees delirantes,” a characteristic feature of West African Psychiatry [47], is an example of a culture-bound syndrome. From a study of 125 cases observed in Fann Dakar, Senegal, over a period of 14 months, Collomb [48, 49] estimated that the incidence of such episodes, compared to other “functional” psychoses, is about 30%. The psychotic episodes are characterized by a sudden, explosive episode, which have a short course. They are more likely to occur when there is some change in relationship or in the environment (e.g., when a person is called upon, owing to outside pressure, to play a part other than a familiar role) [49].

Another proposed culture-bound syndrome is isolated sleep paralysis (also known as “the witch is riding you” or “the haint is on you”), a state experienced while awaking or falling asleep and characterized by an inability to move although being wide awake [30, 50]. This syndrome was found to have occurred at least once in 41% of 108 African Americans participants composed of 36 controls (nonmentally ill people), 36 precare participants (nonpsychotic, anxious patients who had never been psychiatrically hospitalized), and 36 aftercare participants (psychotic patients who had previously been hospitalized for psychotic illness) [30]. It was later discovered that a recurrent pattern (one or more episodes per month) of isolated sleep paralysis in African Americans was described by at least 25% of the afflicted study participants [50]. In this study, frequent episodes were associated with stress, and participants with isolated sleep paralysis had an unusually high prevalence of panic disorder (15.5%). These results have been replicated by several other research groups [51–53]; thus, it has now been firmly established as a culture-bound syndrome in African Americans.

Treating People of African Descent in the USA

Regardless of distress or syndrome, treatment can significantly help in reducing or even alleviating distress and disorder. However, in order to be most potent, treatment should be culturally sensitive. There are four key goals in the assessment, treatment, and cultivation of mental wellness in African Americans. First, it is critical to dispel racial stereotypes and myths within the mental health provider. Second, there is a need to address the significance of the culture. Third, the health professional should be sensitive to the patient’s needs and reality (i.e., their biologic, emotional, intellectual, spiritual, social, and contextual reality). Finally, it is important to discuss and adjust for their expectations. Culturally sensitive (or responsive or humble) treatment can ensure these goals are met.

Cultural Competence

Cultural competence is the ability to effectively interact with others regardless of cultural backgrounds while being “respectful and responsive to the health beliefs, practices, cultural and linguistic needs of diverse population groups” [54]. The term culture encapsulates other characteristics besides race and ethnicity including age, gender, sexual orientation, disability, religion, income level, education, geographical location, and profession [54]. The phrase cultural competence can be misleading, as the term “competence” seems to connote an end, as if one could declare oneself competent. However, our use of competence refers to a journey or process of becoming. This is why the word “competence” could be interchanged with responsiveness, sensitivity, or humility. Cultural competence encompasses a set of skills necessary to build strong working alliances across cultures. It includes awareness, knowledge, and skills [55, 56]. The first component encompasses awareness of our own biases and knowledge that our biases (both tacit and known) can affect our communication with others. It also includes awareness that each one of us has cultural influences and those influences vary depending on person and context. Knowledge includes knowing about our own cultural influences and those of the people with whom we work. This includes history, context, and cultural facets and how these variables influence behavior [56]. Skills refer to the ability to practice efficaciously one's profession with the knowledge of culture. These skills could include assessment, diagnosis, treatment, and self-development. For example, there are certain cultures where family is of central importance, the main support system. Therefore, it may be best for the patient/client's progress if the family were included in assessment and treatment [57]. Other skills include emotional intelligence, social intelligence, and cognitive skills, all of which help to enhance awareness and manifest strong relationships and working alliances [29].

If a professional is not moving forward on this continuum, there are potential dire consequences. A patient's life may be at stake if that person does not understand or accept life-saving information. There are myriad preventable diseases and risky behaviors. With the right message given in the right way, many of those diseases will actually be prevented [58]. For example, Coles et al. [59] have shown that vitamins and mineral supplements given during pregnancy can reduce the negative outcomes of fetal alcohol exposure; however, such an intervention would need to be culturally competent to get traction, especially in PAD where the problem may be greater [60]. Based on studying CHRNA7 (the a7-nicotinic acetylcholine receptor gene), Freedman's team at the University of Colorado have evidence that giving pregnant women phosphatidylcholine may prevent schizophrenia, autism, and attention deficit hyperactivity disorder [61]. Thus, cultural sensitivity is not only advised but it also should be required for those in the helping professions. Cultural sensitivity would preclude inadvertent microinsults from being ignorant of African American culture.

Awareness: Know Thy Self

Since human behavior is theoretically caused by the influences of biology, personality, and familial, sociological, and cultural contexts [62], it is multi-determined and complex. Neurological automaticity adds to this complexity of human behavior and leads to automatic stereotyping. This natural and, most of the time, protective process [63] can become destructive to others when applied to people. Due to the social atmosphere in which Americans live, we are repeatedly exposed to stereotypes about groups of people (e.g., Muslims are terrorists, African Americans are athletic, women are bad at math). Even if a person purports to not be racist, sexist, or classist, their implicit beliefs are infused with these concepts [63, 64], and, therefore, affect expression, interaction, decisions, and behaviors [65, 66]. Lewis et al. [67] conducted a study finding that, when presented with a case vignette where the race in the vignette was artificially altered to be either Afro-Caribbean or White, 63% of British psychiatrists perceived the Afro-Caribbean case to be more violent and more criminal. They were more likely to diagnose the Black person with a cannabis psychosis and acute reactive psychosis than a disorder not associated with illegal drug use.

Confounding this stereotype phenomenon is the seemingly biologically based in-group/out-group bias [68]. Studies have shown that we have a neurological preference for our own group and lack of empathy for out-groups [66, 69, 70]. For example, Xu et al. [69] found that when a racial group looks at pictures of people in their own group experiencing physical pain, their anterior cingulate cortex (ACC) activates. However, when looking at pictures of members of a racial out-group experiencing pain, ACC activity dramatically diminishes. In other words, empathy was reduced to near null for racial out-groups. Fortunately, there is evidence that rectification is possible.

Firat and colleagues expanded upon previous research on neurobiological responses to racial out-groups by examining how the brain responds to racial out-groups in positively valued social positions versus less valued social positions [71]. Participants were instructed to look at a series of pictures of people, animals, and objects. The pictures of people were either African American or White and were depicted wearing certain clothing and accessories as well as participating in activities that would be reflective of those commonly associated with lower-class, middle-class, and upper-class status. The participants were then asked to identify one of eight emotions that were elicited from the picture. The results indicated that the participants identified more positively related emotions to White middle-class people than middle-class African Americans. Researchers also performed the same experiment with an fMRI and found that there was greater ventromedial prefrontal cortex (vmPFC) activation while viewing pictures of White middle-class people when compared to African American middle-class people. This finding further provides evidence that the vmPFC's role for racial evaluations is largely confined to the more positively valued and prized groups through regulating positively related emotions [71]. Additionally researchers found that there was lower right amygdala activation for White lower-class individuals compared to African American individuals which is consistent with previous findings that the amygdala plays a role in racial evaluations particularly for out-group class conditions [71].

Being aware of our context and, how context influences human thinking, including each mental health professional, is vital to effective mental health treatment with African Americans and other marginalized groups. If professionals are not aware of what is "in the water we're swimming in," we are likely to "spit something out" that can harm a patient/client. Microaggressions are examples of ways professionals can inadvertently offend a patient/client. They are unintentional slights against a person because of their group [72]. For example, if someone walks into a store, sees a Hispanic customer, and asks where to find the milk aisle, he/she may have committed a microaggression by assuming that the person works at the store. Again, microaggressions may often be unintentional and go unnoticed by the offender. It can be detrimental to the relationship with a patient if these are done repeatedly and without awareness [11].

Knowledge: Know the Culture and Context

As stated previously, the culture of PAD is quite diverse and multifaceted. However, there are some core cultural-historical factors that have been staples in the Black community, including religion/spirituality, extended family, and racial socialization. There are also core cultural variables, including class and acculturation that deeply influence behavior and can affect perception of treatment. Regarding context and regardless of decades passing since the Civil Rights Act in 1964, mental health professionals should be aware that many African Americans continue to face significant interpersonal and institutional racism [73].

Religion/Spirituality Religion and the Black church have been central protective factors in the history of PAD and continue to be noted as integral when working with the Black community. Historically, the Black church built schools and served a strong political role, progressing civil rights and creating group solidarity. Although this institution is not as strong as it once was, it continues to be a major protective factor and has much potential for uplifting the current community [74]. African Americans report more church attendance and prayer [75, 76]. These institutions have been shown to help prevent risky behavior in youth [77, 78] and act as an extension of one's family. African Americans report being more likely to get support from their church or a religious institution than mental health professionals [34].

Extended Family For African Americans, extended family is another cultural protective factor, as it transcends the physical ties of blood. Friends, religious members, and neighbors are considered family, equivalent to aunts, uncles, and cousins [79]. Despite the disruption of the nuclear family in the Black community [28], extended family has served a vital role in caring for children, supporting mothers, and serving as role models [80]. Extended family has also been cited as important for supporting family members in their health and preventing fatal diseases and mental health illnesses [81]. This type of family can act as a community and, thus, potent protective factor, surrounding and supporting the child, family, or adults.

Racial Socialization and Acculturation Racial socialization is central in identity development [82]. Positive racial socialization is imperative to counteract the myriad negative stereotypes of African Americans present in US culture and established systems to reinforce them (e.g., criminal justice system [19]). When manifested in the home, youth have been shown to do better in school, regulate their behavior, and have higher self-esteem [83].

Considering that racial socialization is protective of African American youth, it only makes sense that anything that would erode such socialization would be a potential risk factor. Such is the case with acculturation. In a large epidemiologic study Burnett-Zeigler et al. found “a sense of pride, belonging, and attachment to one’s racial/ethnic group and participating in ethnic behaviors may protect against psychopathology; alternatively, losing important aspects of one’s ethnic background through fewer opportunities to use one’s native language and socialize with people of their ethnic group may be a risk factor for psychopathology” [84].

Family and Class A perpetual stereotype of African Americans is that they are poor, raised by a single parent, from matriarchal households headed by unemployed women with several children. Ostensibly, this is not true for most African Americans. Additional truths should be highlighted to help dispel such stereotypes. In seminal work [85], Willie described major distinctions by class in the Black community. Over a 30-year period, he had students conduct structured interviews with thousands of Black families. He found that decision-making, power structure, areas of employment, routine, values, religious activity, parenting, and number of offspring varied by class.

He found that middle-class African Americans are typically conformist [85]. Many middle-class parents have dual employment and often in the public sector, such as post offices or public schools. The power structure is usually egalitarian, and family functions are shared and not delineated by roles or gender. Education, work, success, and self-reliance are highly valued. Families are usually made up of two parents and two kids. Parents usually own a home (perceived as a mark of success), are achievement oriented, and upwardly mobile. They are also active in at least one social organization and in community affairs. Most of the picture for middle-class Black families is quite similar to the traditional family values and structure in the USA. Belgrave and Allison [86] note that, in many of these cases, Black individuals have adopted US values more than the average European American. Clearly, this reality does not conform to the negative matriarchal stereotypes about African American families. Knowledge of these facts is useful to prevent mental health professionals from micro-insulting their patients because of the professional’s negative stereotypes.

Willie [85] found the life of working class African Americans to be characterized by hard work, little leisure time, struggle, and necessary interdependence. Parents are usually working in positions requiring manual labor or are in semiskilled positions (e.g., secretary, certified nurse). Many times, parents are literate and most have completed school with some dropping out of high school. Some went on to college or had some trade work training. The power structure is patriarchal; however, roles are often divided by gender with men deciding about money, maintaining the house, and advising the boys. The women cook, clean, and advise the girls. A mother, father, and around four children usually constitute family. Family is a source of pride and parents define good behavior for their children as them staying out of trouble from the police. Religion is important and these families tend to attend church weekly. Approximately one-third had moved up from poverty or down from middle class. They tend to be good examples of self-reliance and can be thought of as innovators as they are creative in developing adaptations for survival. Thus, Willie’s [85] seminal works provides mental health professionals with counter stereotypical concepts of working class African American families.

The life of low-income African American families is typically characterized by struggle, mistrust, and tenuousness. Due to their financial hardship, they make necessary, clever, and sometimes foolish arrangements to survive. These arrangements are often against conventional mores, such as living with extended family or caring for foster children for pay. Due to these life challenges, they have learned to expect little and not trust. This mistrust includes society but it also pertains to romantic partners and, thus, marriage is less likely. If marriage does occur, it is typically at an early age. Children are often born out of wedlock, and family size includes approximately six children. They love their children but have difficulty understanding and effectively communicating with them. They contraindicate following certain misbehavior patterns, but these warnings are often ineffective, as there is little concentrated or concrete effort at prevention. However, there usually exists a strong sense of loyalty between mothers and their youth and between siblings to face the struggles. Circumstances are transitory and jobs, homes, communities, and romantic partners often change. Thus, they experience frequent disappointment. Unemployment is a constant and likely specter. Parental employment usually takes the shape of unskilled labor, like house cleaners or factory workers. Parents have usually dropped out of school and, thus, portray themselves to their youth as failures. Idioms of distress such as drinking, drugs, and gambling may be more frequent to escape temporarily from the stress of this life. Community participation is rare, and they have experienced recurring failures and disappointments. Many times, this leads to them treating society in kind—rejecting it. Religion is a place of solace for some, but it has been rejected for others. In short, they could be seen as rebels. Here in Willie's [85] works, we find the source of the negative stereotypes of the African American family, but with a major important difference that minimizes the demonization of the poor African American family, i.e., the situational sociological context that makes it necessary for poor African American families to functions as many do.

Racism "For the average black person, literally hundreds of racist incidents crash annually into his or her life" [16]. The old saying that "sticks and stones may break my bones but names will never hurt me" is not accurate, as racism has been linked to hypertension and heightened levels of cortisol [87, 88]. Pierce [89] equated the effects of racism to that of terrorism and disaster, asserting that experiencing racism is essentially traumatic. He conveyed that microaggressions impinge on a person's space, time, energy, and freedom of movement. When exposed to myriad offenses over time, the victim is likely to adopt a defensive, apologetic, and/or deferential mental stance.

Albeit two decades have passed since Pierce's assertion, these insults are still as prevalent and pernicious [11]. Although some purport that we live in a "post-racial society," this perception is actually antithetical from the truth. Alexander [19] eloquently provides significant evidence that there is a "New Jim Crow," and this perpetuation of structural racism is in the form of mass incarceration. Black and brown people, especially men, are unfairly targeted by police [90]. It is important for the mental health professional to know the social and structural barriers African Americans face for if this is ignored, there can be premature termination [91], and treatment will be ineffective. Burkard and Knox [92] found that professionals who adopt this post-racial society reality are less successful with their Black patients/clients. Those who had a color-blind racial perspective were likely to disregard their Black patients' contextual reality and, instead, believe the patient to be lazy. They placed the responsibility of solving the problem more often on their Black patient/clients than their White clients. This type of misconception and consequent conceptualization and treatment is damaging and perpetuates disparities. Due to microaggressions such as these, "… racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity" (p. i) [2].

Skills: Assessment, Diagnosis, and Treatment

The application of culturally competent clinical skills which are sensitive to the unique qualities of African Americans is critical for reducing various inequalities in service delivery and poor mental health outcomes [91–93]. Here, we focus on clinical skills, including diagnosis, assessment, and treatment.

Assessment Due to the history for African Americas and the lack of studies that determine norms and psychometric measures for African Americans [2], the assessment of PAD has been fraught with difficulties. An early example of this can be found in Lauretta Bender's work on "Behavior Problems in Negro Children" [94] where she noted that the two most distinguishing characteristics of "Negro" children were their ability to dance and their capacity for laziness. In a more recent publication, Adebimpe [95] points out that the Minnesota Multiphasic Personality Inventory (MMPI), widely used in psychiatric research and practice, is biased toward African Americans, who tend to obtain higher baseline scores on a number of scales, including the schizophrenic scale, which means African Americans are more likely to be misdiagnosed as schizophrenic. Unfortunately, this area of study continues to be disregarded [2].

Diagnosis There is quite a long history of misdiagnosis of African American. Bell and Mehta [13, 14] began a series of research studies examining the misdiagnosis in African American patients. They found that there was significant misdiagnosis of what was then called manic-depressive illness (bipolar disorder). Other studies have corroborated this phenomenon of misconceptualization in people of color [96–101]. West et al. [102] found that African American patients were more likely to receive a diagnosis of a schizophrenia spectrum disorder or a non-alcohol SUDs compared with White patients. They were also less likely to receive a diagnosis of a depressive or anxiety disorder when compared to Whites. A number of researchers have estimated that diagnoses of schizophrenia have been given twice as much to African Americans than to Whites [103–107]. Strakowski et al. [101] studied this dynamic and found that African American men with affective disorders identified by expert consensus were significantly more likely than other patients to be diagnosed with a schizophrenia spectrum disorder by clinical assessment and structured interview. Some have argued that this focus on schizophrenia and other more stigmatizing diagnoses are due to structural racism [13, 14, 97, 98]. A manifestation of this racism, and another form of microaggression, is ignoring the history and contextual barriers of a group [11]. Bell, Jackson, and Bell [108] found that 28% of an African American outpatient community mental health clinic sample had historical issues with mental retardation, special education, attention deficit/hyperactivity disorder (ADHD), autism, head injury, and/or childhood trauma, which influenced assessment and had to be taken into account for accurate diagnosis and treatment. Thus, part of the skill of culturally sensitive clinical diagnosis is integrating the culture, context, personal, and family history into conceptualization.

Treatment Mental health treatment can take the form of psychotherapy, support groups, and psychopharmacology, among other forms; however, these three are highlighted here for African Americans.

Psychotherapy and Support Groups

As mentioned previously, there are four key goals in treating African Americans [109]. Within psychotherapy, it is important that these are addressed in the relationship between patient/client and therapist. First, the therapist must engage the awareness of his/her own biases and explicitly confront his/her stereotypes of African Americans. This process should be done before and throughout the relationship with patients of African descent. If this is not directly confronted, microaggressions may occur or misdiagnosis may result. Microaggressions can offend patients/clients and, hence, disrupt therapeutic rapport. Second, addressing the significance of the race of the patient/client is critical. Although the evidence is limited, most White therapists avoid this conversation [110]; however, avoiding it does not void this underlying dynamic, and what is unsaid can seep into other areas of the relationship. Third, it is important to be cognizant and appreciate the patient's/client's needs and reality. As stated previously, if context is not considered, the therapist may misconceive the patient's/client's psychodynamics and provide ill treatment. Furthermore, critical needs may go unmet that are essential for improvement. Fourth, the therapist needs explicitly to discuss the patient's expectations about therapy: what it will look like, how it will end, what the process is, or expectations around possible results. Finally, throughout treatment, from assessment to termination, there should be a focus on strengths. The clinician's ability to elicit and capitalize on the patient's/client's inherent strengths fosters a more collaborative therapeutic relationship and allows the patient/client to recognize that they are in possession of the tools to aid in their treatment and recovery [111].

Given the importance and potential support of family, the use of multiple family groups has been found effective in both treatment and prevention for African Americans [81]. Multiple family groups are constituted by different members of families coming together with other families to learn and support one another. This form of therapy has been used to prevent risky behavior in youth, strengthen families, and build community cohesion [80, 112].

Psychopharmacology

Pharmacotherapy, for certain illnesses, is a vital part of treatment, and unfortunately, African Americans utilize psychiatric medications at lower rates than White individuals [113]. Pharmacokinetics determines steady-state concentrations of drugs and their metabolites. The activity of liver enzymes, a major determinant in pharmacokinetics, is determined genetically, although environmental factors can alter genetic activity. Understanding the genetics and environmental influences (e.g., use of medications, drugs, diet) of different populations may help to predict side effects, blood levels, and potential drug–drug interactions.

Although race is a sociologic construction and not a biologic reality, there are some biological heritable differences between different ethnic groups. Accordingly, while the biology of the human race is essentially the same, there are some cultural and ethnic differences and some differences in biological heritage that cause some African Americans to be unique in their biological makeup. These unique differences require consideration in the pharmacological treatment in African Americans. Unfortunately, recruitment of African Americans in clinical trials has historically been low due to barriers such as mistrust, stigma, and competing demands [114]. As a result, there is a poor understanding of similarities and differences between various cultural, racial, and ethnic groups regarding their potentially unique pharmacokinetics. Accordingly, psychiatry is bereft in knowledge regarding effectiveness, safety, and tolerability of psychopharmacology in African Americans.

Fortunately, research and clinical practice indicate that usually individual variation is more substantial than cultural/ethnic variation. This reality makes it dangerous to simply make stereotypic assumptions about different cultural, racial, and ethnic groups. However, despite this actuality, exceptions and recognition of these idiosyncrasies can be extremely important for individual patient care. The CYP450 enzymes known for their metabolism of various drugs and toxic compounds are influenced by genetics and heritability as well as environment, which can also be shaped by ethnic influence. CYP2D6, the enzyme that metabolizes tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), non-tricyclic antidepressants (mirtazapine atomoxetine, venlafaxine), and antipsychotics (clozapine, risperidone, haloperiodol, chlorpromazine, perphenazine), is genetically highly polymorphic. Due to this enzyme's genetic variability, individuals can have different activity levels resulting in varying degrees of drug metabolism classified as poor, intermediate, extensive, or ultrarapid metabolizers [115, 116]. Additionally, CYP2D6 is responsible for the metabolism of multiple non-psychotropic medications including opiates, antiarrhythmics, beta-blockers, and antiemetics which can result in unfavorable side effect profiles depending on the individual's CYP2D6 activity level [116].

Research has demonstrated that the incident of poor metabolizers is 1.9–7.3% in African Americans compared to 3–10% in Whites. However, researchers have identified a genetic variant in CYP2D6 found in 33% of African Americans which results in "intermediate metabolizers" who typically do not experience drug toxicity at low doses, unlike poor metabolizers; however, they are more likely to experience medication side effects from lower doses [115]. The genes primarily responsible for lower CYP2D6 activity levels resulting in poor and intermediate metabolizers is CYPD6∗17 and CYP2D6∗10. The gene CYP2D6∗4 is found in Whites is responsible for poor drug metabolizers [115].

Ethnic variation is a major confounding variable in genetic studies and causes major difficulties in understanding genetic coding systems that interact with the environment and genes that determine the essential functioning of the brain. For example, there is a wide ethnic variation in a repeat-length polymorphism within the promoter region (5-HTTLPR) of the serotonin transporter gene (SLC6A4) [117, 118]. African Americans are known to have lower frequencies of the allele responsible for shorter lengths of repeat sequences (S allele) compared to Whites. Given that serotonin transport in the brain has significant clinical importance, this variant found in African Americans could potentially play a role in certain psychiatric conditions [117, 118]. Caspi and his colleagues have shown that the S allele moderates the risk of depression primarily through an interaction with life stressors such as early childhood trauma [119]. These findings suggest that African Americans have unique genetic factors that could contribute to certain psychiatric conditions, considering the prevalence of early childhood trauma in African Americans [119].

Lastly, studies have also demonstrated that elderly African Americans may be more susceptible to tardive dyskinesia (TD), a severe condition secondary to side effects related to antipsychotics that can result in involuntary movements of the extremities and orofacial muscles [120–122]. It is possible that variations in metabolism of antipsychotics contribute to this vulnerability of developing TD.

In summary, evidence from differences in enzyme activity suggests African American patients should receive lower doses of many antipsychotic agents [123, 124]. However, African Americans routinely receive higher doses of antipsychotic agents, are more likely to receive depot injections, experience higher rates of involuntary psychiatric hospitalizations, and have significantly higher rates of seclusion-restraints applied to them while in psychiatric hospitals [125–127]. Further, African American adolescents with bipolar disorder were nearly twice as likely to receive antipsychotic agents (86% vs. 45%) than European Americans [128].

Due to the increase in the antipsychotic medication side effects, extra pyramidal symptoms (EPS), and TD in African Americans, the newer atypical antipsychotic medications (i.e., risperidone, olanzapine, and quetiapine) may be of more value in treating these populations. Unfortunately, atypical antipsychotic medications impair glucose metabolism by causing insulin resistance (unrelated to weight gain), cause significant weight gain, and are associated with hyperlipidemia [129]. Since many African Americans have greater baseline risk for obesity, diabetes, and heart disease, this potential side effect of atypical antipsychotics should be monitored very closely in African Americans. In one longitudinal study in clozapine-treated patients, African American patients had dramatically elevated hazard ratio, compared to White patients, for both new-onset diabetes mellitus and death from myocardial infarction [129].

Other biological concerns are the reality that African Americans have a significantly lower baseline white blood cell count than non-African American patients ("benign neutropenia"). This may prevent trials or early discontinuation of clozapine in this population, though the risk of agranulocytosis appears to be the same as other populations [130].

It is critically important for psychiatrists to establish firm rapport with African Americans before prescribing medications for them. It is important because many African Americans have been inundated with antipsychiatry literature and do not trust psychiatrists or the medication they prescribe [131]. Understanding the patient's/client's beliefs about the causes of their problems and what they expect from treatment, neutralizing their shame and fear of stigma, exploring their sources of strength and support, and ascertaining their use of alternative medicine is critical to successful assessment and treatment. Explaining potential side effects of medications in an understandable manner (e.g., the short-term side effects of antipsychotic medication are shaking, muscle cramps, and stiffness, and the long-term side effects are persisting abnormal movements and weight gain) is more effective than a technical explanation that can be given depending on the patient's education.

Conclusion and Future Directions

The field of mental health has significantly progressed since the days of enslavement as it relates to treating PAD. However, there is still much to be learned and ways to grow.

Research

More research is needed in understanding mental health symptom manifestation for PAD. We need to develop valid and reliable tools for both research and diagnosis—tools that use healthy PAD from different income brackets as the primary reference point to develop norms for PAD. Additional research is also needed around the strengths and protective factors of PAD. For instance, the rate of suicide is the lowest among African American women [132]. There is clearly something around strengths to be discovered here that can be applied to mental health treatment for PAD [133].

Given that there is a lack of PAD in clinical trials, future research should also focus on their inclusion [114]. The findings that arise from better representation can help the field understand treatment facets like dosing, efficacy, safety, and tolerability of psychotropic medications. New drugs that are approved by the Food and Drug Administration should be adequately studied in PAD prior to being allowed on the market.

Future research should also attend to the prevalence and effects of fetal alcohol spectrum disorder (FASD) in youth and adulthood. In Canada, FAS is quite prevalent in their juvenile justice system with a rate of 19:1 who have FAS [41]. This research has not been conducted here in the USA. However, with the number of liquor establishments in low-income Black communities and this noted idiom of distress, it is likely the USA would see a similar underlying picture [41]. First, the research should verify this probable reality, and then research and practice for African Americans must move forward strongly in addressing and preventing this spectrum disorder. Prior to research on occurrence, we need a diagnostic tool that can be used in adolescence and adulthood, for it is challenging to diagnose FASD without a baby picture or an honest answer from a parent. Solving this issue may be potentially transformative, as FASD may be a fundamental cause of disruptive behavior leading to (warranted) juvenile detention or special education (Note: we stress "warranted" to establish this as being different from and/or confounding the New Jim Crow phenomenon). The deficiency in choline that fetal alcohol exposure creates is hypothetically responsible for the higher rates of Alzheimer's disease seen in African Americans. Maternal choline supplementation has been proposed as a prevention/treatment strategy for both Down's syndrome and Alzheimer's disease [134]. This hypothesis is based on the finding that mice (genetically altered mice to develop the neuropathological changes in Down's syndrome and Alzheimer's disease within 6 months) have been used to discover prevention/strategies for these two disorders and research has demonstrated that maternal choline supplements are a protective factor against the degeneration of basal forebrain cholinergic neurons seen in these two conditions. Thus, by increasing choline in prenatal vitamins, the scourge of fetal alcohol spectrum disorder and Alzheimer's disease in African Americans may be abated [135].

Alzheimer's disease is reported to be twice as high in African Americans compared to rates in European Americans, and, while this may be related to the rates of fetal alcohol spectrum disorder in African Americans, something must be done to treat the African Americans already afflicted with Alzheimer's disease [136]. Until the putative connection is made between fetal alcohol spectrum disorder and Alzheimer's disease is shored up by additional research, the problem of treating Alzheimer's disease in African Americans needs to be explored. The first author's clinical experience is that memantine and donepezil do not do a great deal to help patients with Alzheimer's disease; however, escitalopram does seem to decrease agitation such patients, calms their anxiety, and brightens their affect [136]. Further, there is evidence that such SSRI medications may significantly reduce amyloid deposits in the brain and may be secondary treatment strategy for patients with Alzheimer's disease [137]. However, while such clinical research, also known as "bent nail" research [138], may give important clues on how to approach research on African Americans, there is still a great need to do formal academic research on these issues.

Enhancing Cultural Sensitivity

There are relatively few mental health professionals of African descent and definitely not enough to meet the mental health needs of PAD. This simple ethnic matching could help to increase access to services, as Black mental health professionals tend to service more Black patients than White professionals [110]. This also will likely make the services more welcoming, given the mistrust and stigma persists [4]. In addition, both non-White and White clinicians and researchers should be trained in cultural sensitivity throughout medical training. Lu and Primm [139] provide guidance in promoting cultural competence in medical school. Training in cultural sensitivity and competence can be assessed using tools, such as the Association of American Medical Colleges' Tool for Assessing Cultural Competency Training [140]. This tool includes items touching on history, knowledge, skill, and attitudes in various facets of cultural competence including the impact of bias or stereotypes on decision-making. The *Diagnostic and Statistical Manual*, 5th Edition's Cultural Formulation [141], can also assist in manifesting cultural competence in treatment of PAD [139].

Prevention

Despite the efforts that have been made to increase access and improve healthcare quality for people of color and low income, health disparities persist [6]. Prevention is one solution to this predicament. The near alleviation of polio through prevention is one exemplar of the power of prevention. We now know that prevention saves millions of dollars, decreases violence, strengthens family, and saves lives [142]. Fortunately, for mental health in particular, prevention is alive and well. However, there is still significant work needed in this area. The information provided in this chapter, regarding the unique characteristics of African Americans, various biopsychosocial factors, and implications of psychiatric treatment options, will hopefully encourage clinicians to integrate these principles into practice, which could potentially mitigate psychiatric symptoms within this population.

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8

American Indian and Alaska Native Mental Health

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Selected Cultural Characteristics and Perspectives on American Indian and Alaska Native Mental Health Services and Treatment Approaches: An Overview with Reservations

In recent decades considerable research has focused on the mental health, social pathology, and psychopathology of American Indians and Alaska Natives [1–5]. Most of the research offers interpretations as to the causes of a variety of emotional and behavioral disturbances. Conjointly with theory, interpretations are offered as to why the particular problem under investigation should persist within the individual or group. Yet the authors offer little in the way of substantive and systematic recommendations or solutions for the diagnosed problems. Moreover, they ignore the question of whether the problems are worthy of a solution from the perspective of the native people themselves. State and federal governments, private foundations and organizations, and church-related institutions are aimed at resolving problems of Indian mental health, yet the problems still persist. A cursory examination of the social indicators indicative of mental health in any American Indian community would indeed support this contention.

It is time for a reassessment of what has been written, conceptualized, and put to use in treatment and prevention. Mental health practitioners and scholars cannot continue to compile volumes of pragmatic, descriptive, and interpretative research without an ultimate objective. An objective of applied science is to offer practical solutions to problems. However, a point has to be reached where solutions must supplement understanding. At present, it seems that research alone has been the outstanding feature of the focus on American Indian and Alaska Native mental health. This calls for a revision in a basic conceptualization of the research model and the types of data analysis that are or have been used, as well as their subsequent utilization.

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Our purpose here is to reassess the current knowledge available that describes the mental health processes occurring among American Indians and Alaska Natives. The inquiry will further clarify the structure and function of mental health programs that have been established.

To present an overview of American Indians and Alaska Natives mental health issues, we have purposefully avoided specific examples or generalizable guidelines that would mislead the readers due to the extreme cultural and historical differences that comprise the many American Indians and Alaska Natives villages and nations. It is also important to note that in the context of diversity, American Indian and Alaska Native identities are defined politically due to their collective history of being citizens of sovereign nations, not solely by racial, ethnic, or cultural terms.

The general terms, American Indian and Alaska Native, are used to describe the Indigenous people of the continental United States; other terms used in the literature include Indians, Treaty Indians, Tribal, Native Villages, Alaska Native Villages, Native Corporations, Native American, Native, First Americans, Tribal Nations, First Nations, Indigenous Nations, American Indian tribes, Tribal people, Indian tribes, organized bands, Pueblos, Alaska Native villages, tribal communities, Federally recognized tribes, nonfederally recognized tribes, state recognized tribes, Rancherias, urban Indians, reservation tribes, reservation Indians, or specific tribes. Many other tribally oriented nonfederally recognized groups exist and may be seeking federal recognition of their status including those tribes that are state recognized but not federally recognized. Federal recognized tribes designate a specific trust relationship with the federal government.

To effectively and competently provide mental health services for American Indians and Alaska Natives, one must understand the extraordinarily diverse demographic and individual identity characteristics of the groups that make up North America's Indigenous populations. These populations are no doubt more diverse than those that make up the rich tapestry of national and ethnic groups in European countries. American Indians and Alaska Natives reside in 50 US states. An unknown number follow traditional lifestyles, and countless others embrace the values and lifestyles of the common North American culture. The extraordinary variation in lifestyle orientations and physical appearance among American Indians and Alaska Natives presents a daunting challenge for anyone who tends to view American Indians and Alaska Natives as a homogeneous group [6].

Indeed, the tendency of non-Natives to view American Indians and Alaska Natives in a collective manner has been a source of considerable concern among scholars. It may well be the major reason so many non-Natives experience difficulty in understanding the complexity of the varied lifeways and thoughtways of American Indians and Alaska Natives. Later, we present some definitions as well as information concerning demographic patterns among American Indians and Alaska Natives to show how diverse the population is and to demonstrate why it is impossible to create a monocultural silhouette that portrays "Indianness" in a compendious manner. Mental health professionals must be aware of the variations and distinctions if they want to work effectively with American Indian and Alaska Native clients.

Historically, psychopathology, mental health, and personality among American Indians and Alaska Natives (following a 1978 resolution by the National Congress of American Indians, people Indigenous to North America are referred to as "American Indians" and "Alaska Natives," except when specific tribal designations are appropriate) held an enduring fascination as objects of study for social scientists. Native scholars note the apparent unceasing stream of biased research findings, case studies, and critical commentaries that flowed from researchers and practitioners [7, 8].

Moreover, a majority of programmatic efforts to provide services in American Indian and Alaska Native mental health were guided by Euro-American psychiatric and professional traditions (see [9, 10]). It has been demonstrated that the Euro-American practices conflict with the basic worldview of many American Indian and Alaska Native communities [11]. Continuation of these practices will in all likelihood create more problems than are solved. Miranda et al. [12] reported that American Indian and Alaska Native populations are largely missing from the literature on the effectiveness of mental health care and that the limited literature focuses on prevention strategies with American Indian and Alaska Native youth. Bernal and Scharron-Del-Rio [13] suggest that, "it is essential that researchers construct theories of psychotherapy and evaluate treatments grounded in the realities and experiences of ethnic minority populations" (p. 337). In addition, Bernal and Saez-Santiago [14] reported that too few studies have (a) incorporated culture and ethnicity as part of the intervention, (b) tested the effectiveness of such interventions, (c) articulated and documented how ethnicity and culture play a role in the treatment process, and (d) described how interventions may need to be adapted or tailored to meet the needs of diverse families.

There have not been many studies about American Indian and Alaska Native attitudes regarding mental health and mental illness. There is a general American Indian and Native Alaska worldview that encompasses the notions of connectedness, reciprocity, balance, and completeness that frames their views of health and well-being. Studying this experience may help lead to the rediscovery of the fundamental aspects of psychological and social well-being and the mechanisms for their maintenance.

In the last three decades, mental health services delivered to American Indians and Alaska Natives have grown dramatically in terms of general availability as well as in the range of care offered. This growth can be attributed to a number of factors, notably changes in federal public health policies, increasing tribal resources and expertise, and community demands for more comprehensive and "culturally relevant care." The rapid expansion of mental health services to American Indians and Alaska Natives has, however, frequently preceded careful consideration of a variety of questions about several critical components, such as care, specifically, the delivery structure itself, treatment processes, program evaluation, epidemiological data, and preventive strategies. However, as a more informed perspective toward American Indian and Alaska Native mental health is emerging, federal and state agencies are now initiating and implementing new and more culturally sensitive mental health programs.

Simultaneously, more accurate research and reporting are emerging. For example, recently many federal agencies have developed initiatives under the directive of health disparities research to promote preventive intervention efforts in American Indian and Alaska Native communities [10, 15, 16]. These interests and the initiatives are positive steps and have potential for improvement of mental health conditions.

While improvements have been made, a recent report by the Department of Health and Human Services Office of Inspector General [17] found that:

- Eighty-two percent of Indian Health Service (IHS) and tribal facilities reported that they provide some type of mental health service; however, the range of available services is limited at some facilities.
- Staffing issues and shortages of highly skilled providers limit American Indian and Alaska Native access to mental health services at IHS and tribal facilities.
- Physical, personal/social, and economic challenges may affect access to mental health services at IHS and tribal facilities.

The report concluded that the high rates of suicide, substance abuse, depression, unemployment, and poverty in American Indian and Alaska Native communities demonstrate the need for access to mental health services. Although over 80% of IHS and tribal facilities reported that they provide mental health services, these services are limited by shortages of highly skilled providers and specialty areas and by other staffing issues. Furthermore, the majority of American Indians and Alaska Natives seeking these services live in rural areas and face physical, personal/social, and economic barriers that limit access. The report recommended that IHS:

- Provide guidance and technical assistance to help tribes explore potential partnerships with non-Indian and Native providers of community mental and behavioral health services.
- Continue to expand its telemedicine capabilities and provide guidance and technical assistance to tribal health-care providers to expand and implement telemedicine.
- Develop a plan to create a single database of all IHS and tribal health-care facilities.

Mental health disorders are a known risk factor for suicide in the general population and ranked second of the ten leading causes for hospitalizations among American Indians and Native Alaskans aged 5–14 and 15–24 in 2016 [8]. Recent data on the prevalence of specific mental disorders among this population are limited, but evidence suggests they are at increased risk for a range of mental disorders due to historic trauma and low utilization rates for mental health services [9, 10].

American Indians and Alaska Natives experience serious psychological distress, 1.5 times more than the general population [8]. American Indians and Alaska Natives experience PTSD more than twice as often as the general population [8]. Although overall suicide rates are similar to those of whites, there are significant differences among certain age groups. Suicide is the second leading cause of death among 10–34-year olds American Indian and Alaska Natives, whereas the suicide rate among Native people that are more than 75 years old is only one-third of the general population [8]. Also American Indians and Alaska Natives use and abuse alcohol and other drugs at younger ages, and at higher rates, than all other ethnic groups which is a factor in suicide attempts and completions with this population.

The Center for Disease Control and Prevention, for example, reports more specifically that from 2003 to 2014, the suicide rate for American Indians and Alaska Natives has been increasing and was higher than the overall US rate; the highest rate of suicide was with Native females aged 15–19; suicide was the sixth leading cause of death for American Indians and Alaska Natives males of all ages. Suicide ranked first in leading cause of death for females aged 10–19 and second leading cause of death for Native males aged 10–34. They also reported that in this same period, American Indian and Alaska Native males in the 15–19 age range had the highest suicide rate compared to same-age males of all other ethnic groups.

A recent report by scholars of American Indian Alaska Native suicide linked suicide to behavioral health problems, such as anxiety, substance abuse, and depression and also called attention to victimization, discrimination, and acculturation stress [18]. They also reported that in this same period, American Indian and Alaska Native males in the 15–24 age range had the highest suicide rate compared to same-age males of all other ethnic groups. They linked suicides to distrust of formal services, underutilization of services, lack of resources to ensure safety (e.g., absence of law enforcement on rural reservations, rural allotments, and Alaska Native villages), ongoing marginalization, poverty, underemployment, lack of basic services, and collective disempowerment [18]. Finally, other reports note the major disruptive impact of forced assimilation across generations on tribal unity, family strength, and typical coping strategies [19].

Some key protective factors against suicide attempts among Native youth include [20] discussion of problems with family or friends, connectedness to family and community, and building motional health. But there are major barriers to accessing mental health that include economic barriers (cost, lack of insurance), lack of awareness about mental health and available services, stigma associated with mental illness, lack of culturally sensitive mental health services, mistrust of health-care providers, limited mental health services, and lack of appropriate intervention strategies (including integration of mental health and primary health-care services).

Given the long history of limitations and meager and misguided attempts at delivering formal services, it is not surprising that the recognition of the stark and immediate needs in these communities due to explosive growth outstripped the knowledge for designing and implementing appropriate programs. The time has come to take stock of the current situation.

To this end, we selectively review the literature relevant to many of the areas listed above. A series of questions are posed as points of departure for future inquiry, the answers to which will, in our opinion, form the basis for significant advances in the delivery of mental health services to American Indian and Alaska Native people. Before turning to a discussion of specific aspects of the delivery of mental health services to this special population, some mention of the broader context is in order, particularly for readers who may be unfamiliar with these communities.

Demographic Patterns

As of 2012, an estimated 5.2 million people were classified as American Indian and Alaska Native alone or American Indian and Alaska Native in combination with one or more other races which is about 2% of the total US population. Twenty-two percent of American Indians and Alaska Natives live on reservations or other trust lands. Many of these lands are remote and cover vast geographic areas that may have limited access to behavioral health services. Between 60% and 70% of American Indians and Alaska Natives live in urban areas—the lowest metropolitan percentage of any racial group. 1.5 million (30%) of American Indian and Alaska Natives are under the age of 18. The 2010 Census revealed that 78% of American Indians and Alaska Natives live outside of tribal statistical areas ([21, 22], retrieved September 7, 2018 from: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62).

Currently, there are 573 federally recognized American Indian and Alaska Native tribes, and more than 100 state recognized tribes. There are also tribes that are not state or federally recognized. To add to this complexity, some American Indians and Alaska Natives people are members of a tribe, whereas others who are also American Indian are not. They may not have sufficient "degree of Indian blood" to qualify them for specific tribal enrollment but may still be eligible for IHS or Bureau of Indian Affair services due to their combined "degree of Indian blood." Tribal nations have unique governments, histories, traditions, communities, languages, and behavioral health challenges [21]. Compared to the total US population, more than twice as many American Indians and Alaska Natives live in poverty. In 2013, American Indians and Alaska Natives men and women were nearly twice as likely as whites to be unemployed [23].

American Indian and Alaska Native communities are culturally heterogeneous, having been classified into distinct regions in terms of differences in language, social organization, religious practice, and ecological relationships. Of the over 300 major American Indian and Alaska Natives languages that existed immediately prior to European contact, approximately 150 are still spoken, excluding hundreds of dialectal variations. To put this into perspective there are about 500 distinct languages spoken among the Indigenous peoples of the vast Amazon basin in South America.

Within the framework of American Indians and Alaska Natives populations, the barriers to mental health treatment are formidable and include quality of care (e.g., fragmented service system, limited funding, unavailable services, and racism) coupled with the desire for self-reliance, privacy issues, communication/trust, and fear of mental health treatment [24]. There are vast differences in what exist from having no trained service providers within a 200-mile range to the recent establishment of an Indigenous private practice behavioral health clinic on a reservation.

Overall, American Indians and Alaska Natives are less likely to have access to mental health service than the general population, receive poorer quality care, and are underrepresented mental health research [25]. In 2010, Senator Byron Dorgan, then Chairman of the Senate Committee on Indian Affairs, released a report citing problems in some IHS facilities related to credentialing and licensing of providers, accountability of controlled substances, and management of funds. These problems were similar to those previously identified by the Office of Inspector General (OIG) and the US Government Accountability Office (GAO). Prior to that, in 1999, and again in 2004, the US Commission on Civil Rights found significant health disparities for AI/ANs as a result of structural and financial barriers, *many of which were similar to problems identified almost a century ago* [26]. The barriers to treatment include a fragmented service system, limited funding, unavailable services, and racism coupled "with distrust and fear of mental health treatment."

The service provision for all American Indians and Alaska Natives is problematic as there are a limited number of professionals trained to work with American Indians and Alaska Natives. The need for appropriate and accessible mental health services in Indian Country is enormous [27]. Mental health services to American Indians and Alaska Natives are delivered by a diverse array of providers, many acting through federal agencies, some through locally controlled organizations, and others as part of private as well as state-managed systems. Eligibility criteria are even more confusing and vary with the provider agency question. Indeed, this confusion prompted a study sponsored by the US Department of Education, Office of Indian Education [28], to determine workable definitions of "Indian." Despite the "definition" of Indian study, bureaucratic ambiguity remains, employing tribally defined membership criteria which differ across regions, blood quantum (frequently one-fourth, genealogically derived), personal identification/community consensus, and various permutations thereof [29]. It is within this setting, then, that the following issues and concerns arise.

Delivery of Services

Mental health services to American Indians and Alaska Natives are provided through private agencies and practitioners, county and state agencies, community mental health centers, the Bureau of Indian Affairs, Bureau of Indian Education, the Indian Health Service, Veteran Administration, urban Indian health and family support programs, tribal health departments, and detention facilities and jails [30]. The nature and extent of services delivered vary with each agency or community organization, as does our knowledge concerning their respective client populations, problems treated, and outcomes.

State and Local Services

Very little information exists on client profiles and diagnostic distribution for American Indians and Alaska Native seeking services from private agencies. Given the availability of services provided by other institutions, it is likely that relatively few individuals seek private care. Numerous American Indians and Alaska Natives from both urban areas and reservations are served by county and state mental health facilities. However, the diverse points of entry into this system—such as state hospitals, day treatment centers, the Social Security Administration, CETA, Department of Justice, hospital emergency rooms, and vocational, rehabilitation sectors—yield a confusing and often unmanageable set of service use data. American Indians and Alaska Natives appear to use mental health services far less frequently than their need for services would suggest [31]. The American Indian Service Utilization and Psychiatric Epidemiology Risk and Protective Factors Project reported that between 21% and 24% (depending upon the tribe) of an American Indian sample were diagnosed with any alcohol, drug, and mental disorder compared to 22% reported by non-American Indians in the National Comorbidity Study [32]. Reasons for low incidence of seeking mental health services included use of primary care for mental health rather than specialized care, most likely due to stigma associated with emotional or mental health treatment, privacy issues associated with confidentiality (e.g., having to receive care at facilities where friends and relative work), and negative social support or criticism for seeking help from people in their social network. Furthermore, clients with anxiety disorders who had concerns interacting with others were also reluctant to seek mental health services [33].

Bureau of Indian Affairs

The Bureau of Indian Affairs (BIA) serves tribal governments in the administration of employment and job training assistance, law enforcement and justice, agricultural and economic development, tribal governance, and natural resources management programs to enhance the quality of life in federally recognized tribal communities located in 34 states. Historically, the BIA's responsibilities included providing health-care services to American Indians and Alaska Natives. However, in 1955 the responsibility was legislatively transferred as the Indian Health Service to the US Public Health Service within the Department of Health, Education and Welfare, now known as the US Department of Health and Human Services (DHHS). The BIA is also responsible for the administration and management of 55 million surface acres and 57 million acres of subsurface mineral estates held in trust by the United States for American Indian, Indian tribes, and Alaska Natives. The Bureau of Indian Education (BIE) is a branch of the BIA and provides education services to approximately 42,000 American Indian and Alaska Native students. This responsibility is met through tribal and state contracts, federal boarding schools, and educational and vocational guidance programs. This branch of BIA encompasses child welfare, including care, supervision, and other services for delinquent, dependent, or neglected children, and family services involving counselor interventions related to family breakdown and emotional instability [34]. Mental health professionals and paraprofessionals are employed in both branches. However, their diagnostic observations are seldom a matter of formal record; at best they are expected to refer clients to mental health-care providers, such as the Indian Health Service or the tribal-based behavioral health services. Typically, there is little or no postreferral monitoring. One primary concern of many BIE boarding schools is the placement of youth directly from residential care without formal follow-up or referral into BIE schools [34].

The Indian Health Service

The Indian Health Service (IHS) annually provides inpatient and outpatient care to more than two million American Indians and Alaska Natives, through direct or contract services in 12 regional areas each harboring approximately 772 facilities of hospitals, clinics, and satellite centers [17]. A relatively new but growing component administers social service and mental health programs. Because of varying and limited resources, service provision can range from exemplary to extremely lacking. Many facilities are not able to provide mental health services due to staff shortages of psychiatrists and other licensed providers [17, 34].

Urban Indian Health-Care Programs

Beginning in the early 1970s, American Indian and Alaska Native communities started to assume direct control of the management and provision of health services to their members. At present there are approximately 40 urban American Indian and Alaska Native health programs. These programs—authorized under Public Law 93–437, the Indian Health Care Improvement Act, and implemented on a contractual basis with the Indian Health Service—have only recently expanded to include mental health care and then on a limited basis. Urban Indians are much more likely to seek health care from urban Indian health organizations (UIHOs) than from non-Indian clinics [35]. However, these Indian-operated clinics must struggle to obtain and maintain their funding, resources, and infrastructure needed to serve this growing population. The vast majority of American Indians and Alaska Natives living in cities are ineligible for or unable to utilize health services offered through the Indian Health Service or tribes (i.e., because of access to a facility or tribal enrollment difficulties), so the UIHOs are a key lifeline for this group. The Indian Health Service contracts with private Indian-controlled nonprofit corporations to run UIHOs. Today, there are 34 UIHOs. In fiscal year 2015, Congress spent

$41 million on the program, or about 0.01% of IHS's $6 billion annual budget. The 34 organizations served roughly 100,000 Indian people in 2005.

However, there is no formal public health surveillance system for urban Indians. Federal, state, and local public health institutions might collect such data, but they are rarely disaggregated or separately analyzed [36]. Many standard federal health surveys cannot report accurately on urban Indians, in part because they lack adequate racial designations. In one effort to address some of these gaps, the Urban Indian Health Institute was created as a division of the Seattle Indian Health Board in order to unify data from the UIHOs, identify urban American Indian and Alaska Native health needs, and to clarify health disparities [37]. The majority of current urban American Indian and Alaska Native health data available is the work of the Urban Indian Health Institute.

A summary of urban mental health problem areas in 2007 indicates that (1) American Indian and Alaska Native children, adults, and families have significant and multiple mental health needs, and (2) these needs lie especially in the areas of chemical dependency, vocational/employment/financial, family, learning, emotional and interpersonal, and cultural difficulties. Among the total population, the most frequent problem areas were: chemical dependency, family strife, learning disability or difficulty, physical complaints, and employment. While these issues present themselves at these facilities, this pattern is thought to be representative of just a fraction of the broader American Indian and Alaska Native community [38].

Tribal-Based Health-Care Programs

A similar set of circumstances characterizes tribal health programs. Reservation communities are empowered to assume either partial or total responsibility for the delivery of a wide range of services, including mental health care, as part of Public Law 93–638, the Indian Self-Determination Act. To date, 115 different tribal programs have been established under contract to the Indian Health Service. Less than half of these programs have a formal mental health component due to similar reasons mentioned with urban and federal services: lack of adequate funding, lack of qualified providers, isolated location, stigma, and lack of priority by tribal government.

Service Delivery Considerations

The American Indian and Alaska Native service delivery system is a complicated mixture of multiple service entities guided and impacted by jurisdictional overlays that create significant problems in the delivery of trauma services. According to Manson [27], the system of services for treating mental health problems in "Indian Country" is a complex and inconsistent set of tribal, federal, state, local, and community-based services. The agencies directly responsible are Indian Health Service, Bureau of Indian Affairs, and the Department of Veterans Affairs; other programs providing services are the Department of Justice Office for Victims of Crime, the Office of Juvenile Justice and Delinquency, and Office of Tribal Affairs and tribal health programs; urban Indian health programs; state and local service agencies; schools including profit, nonprofit, and/or religious; and traditional healing resources. Manson's 2001 report on "Mental Health Care for American Indians and Alaska Natives" states that while the need for mental health care is significant, the services are lacking, and access can be difficult and costly [39]. The report lists problems in service utilization patterns that include American Indian and Alaska Native children as being more likely to (1) receive treatment through the juvenile justice system and inpatient facilities than non-Indian children, (2) encounter a system understaffed by specialized children's mental health professionals, and (3) encounter systems with a consistent lack of attention to established standards of care for the population. The proliferation of services within the delivery structure outlined above raises a large number of critical questions, the answers to which can guide future growth and create greater efficacy in care:

Is there a relationship between the form of delivery structure and the degree of service utilization (frequency of return—as well as initial contact)? What are the channels by which information about service availability is communicated to and among American Indians and Alaska Natives? What service programs have successfully engendered participation in planning and operation? How have they accomplished this? Does participation relate to differential program effectiveness? How so? What impact will federal policy changes in service delivery control and eligibility requirements have on delivery structure and subsequent organizational development? To what extent can service duplication be avoided? How can service delivery be restructured to render existing health resources more cost-effective? What is the rate of referral compliance by American Indian and Alaska Native clients? To what extent is it affected by different eligibility requirements across services? How can one increase such compliance?

Native Traditional Healers and Collaboration

Though this chapter focuses on the formal mental health delivery structures, one should be aware of the important and extensive role that traditional healers play in the mental health care among American Indians and Alaska Natives. The function of Native traditional healers and their relationship to Western health-care professionals is an essential but not a necessarily utilized collaboration. It is our opinion that any effort to plan and deliver mental health services to Native communities must take the potential impact upon traditional healing practices into account. Central to wellness and healing is the American Indian and Alaska Native belief held by many traditional people that all things in life have a spiritual nature. It is important to have this understanding. Spirituality as part of the healing process continues to play an important role in the individual and collective well-being of American Indians and Alaska Natives; helpers and healers have been taught words, prayers, practices, rituals, and ceremonies that help connect the physical world with the spiritual world to bring about wellness, balance, and harmony. The spiritual dimension is interwoven and intertwined with the physical, mental, emotional, and relational well-being dimensions [40]. Johnson and Cameron in their [41] review of mental health services with American Indians note the frequent use of traditional healing on a regular basis by both urban and reservation dwelling members of this population. King [35] found that more than half of urban American Indians and Alaska Natives had wanted traditional healing in the past year. Robert Bergman writes about medicine men that were able to provide types of healing that Western medicine could not provide, including the healing of schizophrenia [42]. He mentions one case in particular:

> ... a woman who had been hospitalized several times as a schizophrenic. A social worker and I set out to track her down to see how she was. We found her father first. He agreed to take us to see her but said that maybe we wouldn't be interested anymore because now she was perfectly well. We said that if she was perfectly well, we were even more interested in seeing her. She was at home taking care of several very active, healthy-looking children and weaving a rug at the same time. After a visit of several hours, we agreed that she was indeed well again. (p. 8)

We would do well to collectively and more seriously consider what traditional healers are able to offer the field of mental health as well as develop integrated, holistic services.

Treatment Approaches

Counseling and psychotherapy outcome research has emphasized the importance of client or patient variables, expectation, and degree of disturbance, therapist characteristics, and related factors and considerations. The development of a facilitative relationship or working alliance is also of considerable importance. This interpersonal climate is thought to result from the ability of the therapist to understand the client and to communicate this understanding adequately [43].

Therapy in cross-cultural settings, which characterizes the vast majority of American Indian and Alaska Native mental health experiences, has its most serious problems in those very areas of interaction that have been demonstrated to affect psychotherapy outcome. Cross-cultural therapy implies a situation in which the participants are most likely to evidence discrepancies in their shared assumptions, experiences, beliefs, values, expectations, and goals. Several recent literature reviews indicate that in the absence of this openness, this situation, at its extreme, establishes conditions that are clearly unfavorable for successful therapy, whereas effective cross-cultural therapy allows for the safe and open exploration of these discrepancies. This view is supported by the subjective reports of many clinicians involved in cross-cultural psychotherapy, as well as the limited cross-cultural research conducted in this domain [43, 44].

Complexities in Counseling and Psychotherapy

Given a history of hegemony and cultural annihilation, how might an American Indian and Alaska Native client experience therapy? Among the most notable difficulties is the client's inaccurate or inappropriate perception of the therapist's role and client responsibilities. Thus, there is often a discrepancy between what the client expects and what the therapist interprets as the most beneficial role. This same theme has been emphasized [45, 46] in discussions of the difficulties often inherent in attempts by non-Natives to work with American Indian and Alaska Native clients. They suggest that, in general, traditional therapeutic forms of social or interactional control and influence are viewed by American Indians and Alaska Natives as out of the realm of proper behavior of action and that American Indian and Alaska Native clients frequently react with disquiet, fear, or bewilderment. Clear differences exist and do affect subsequent outcomes.

In addition to the expectations for role performance, the clients of cross-cultural therapy do not always find themselves motivated to change in ways that are congruent with the therapist's goals and value system [46]. Although they may be motivated to seek treatment, they probably do not share as many valued directions of change as participants from the therapist's cultural background and training. Trimble [47] makes exactly this point, citing major differences between White and Lakota [48], Pueblo [11, 49], Hopi [49], and Arapaho [50] cultural values. Moreover, American Indian and Alaska Native clients may hold quite different beliefs about the etiology of their problems and the manner in which change can be accomplished [51–54].

Characteristics of Service Providers

Certain therapist characteristics, qualities, and activities have been identified as contributing to positive and negative outcomes in psychotherapy in general. In fact, many clinicians believe these qualities to be the most important determinants of patient improvement. Therapist variables such as warmth, honesty, self-disclosure, empathic communication, specific personality characteristics, and personal adjustment are among those that have received the greatest attention in empirical studies. This research was initially summarized by Strupp [55], among others, and has been updated on several occasions [42, 56]. The evidence indicates that the quality of the relationship correlates with positive outcomes.

Cross-cultural research suggests that many of the same therapist characteristics are also related to positive outcome between participants from different cultures. Perceived expertness, positive regard and empathy, comfort, and previous cross-cultural experience have been shown to be related to different culture client improvement [57–60]. Considerably more work needs to be done in this regard, especially with respect to the manner in which such variables are defined and operationalized. Little or no data are available on the therapist variables most closely linked to positive outcomes in psychotherapy among American Indian and Alaska Native clients.

Speculation and anecdotal impressions abound yet remain to be evaluated systematically.

Treatment-Related Considerations

To this end, the following questions must be examined within American Indian and Alaska Native communities: (1) What treatment modalities (Indigenous and nontraditional) are available for various forms of psychopathology? (2) What expectancy variables define the therapeutic relationships? (e.g., cultural awareness of the therapist, consideration of cultural aspects in treatment) From the American Indian and Alaska Native patient's viewpoint? From the therapist's viewpoint? (3) What process variables occur between therapists and American Indian and Alaska Native patients? (4) How does one appropriately measure outcome? (5) What constitutes effective treatment? (6) To what extent and under what conditions are treatment modalities differentially effective? (7) Under what conditions and for what reasons are practices and techniques of traditional healers appropriate? The importance of these questions cannot be understated. Many Indian and Native communities are now focusing on approaches that include decolonization and recovery of traditional knowledge as central to their health and mental health. They seek ways to demonstrate that their culture-based or culture-assisted interventions and approaches have accomplished their intended purpose [61–63].

Program Evaluation

Program evaluation proceeds at a different level of analysis than does the measurement of treatment outcomes. It examines specified organizational and service delivery goals in the context of community needs and the subsequent impact of an intervention scheme. Planners and administrators of American Indian and Alaska Native programs advocate evaluation of this nature, but seldom practice it. In those few instances in which such efforts are carried out, program response (in the form of modification or redirection) rarely follows. This seems to be true of the delivery of mental health services in general as well as in the American Indian and Alaska Native case [64]. However, for many of these communities, culturally specific, community-driven interventions often lack systematic research and evaluation to support their effectiveness. Utilizing science to assist with evaluation is problematic because scientific methodologies are developed from a worldview that differs significantly from Indigenous communities. Thus, it is quite difficult for tribes to bridge scientific measurement with Indigenous knowledge (e.g., what constitutes success, how do local communities evaluate effectiveness, etc.) [62].

Utilization of Services

With one major exception, which is discussed at the end of this section, the evaluation of services delivered to American Indians and Alaska Natives has taken the form of studies of reasons for underutilization, or, more specifically, barriers to service. Murdock and Schwartz [65] surveyed 160 elderly Lakota residents of a South Dakota reservation and found the overall awareness of available services to be remarkably low. More than 40% of the respondents were unaware of 15 of the 21 service agencies on the reservation. Awareness of service availability closely paralleled previous differences in perceived need by household type. Elderly persons living alone were less aware of medical, home maintenance, and personal maintenance services than their counterparts residing as couples or with children. Moreover, the former were more aware of social and mental health services, for which they expressed considerable need, but that were sorely lacking. King [35] found that approximately half of an urban Indian sample were not aware of and did not know how to access basic health services.

Additionally, beliefs about the effectiveness of mental health-care staff can affect use patterns. Reporting on their work among the Navajo, Schoenfeld et al. [66] indicate that patient referrals are directly related to the attitudes that program staff holds toward the provider agencies. For example, few, if any, clients were referred to the BIA program since attitudes toward its staff were largely negative. Furthermore, whereas the mental health personnel were viewed positively, a great deal of mistrust existed between them and other agencies, hampering effective coordination of the delivery of services in this community. Similar results were reported by Saylors and Daliparthy [67].

Urban American Indian and Alaska Native leaders and community members share a mutual concern for mental health conditions and availability of services [68, 69]. According to Clark [70], urban American Indians believe that their mental health needs are not being met adequately and that the federal government shares in the responsibility for providing care. Furthermore, available services are viewed with suspicion and hence are underutilized, a recurrent finding among American Indian and Alaska Native populations and other ethnic minority populations [71]. Nonurban and off-reservation American Indian and Alaska Natives apparently experience problems similar to those of their urban counterparts. Many off-reservation American Indians and Alaska Natives and those who have been “disenrolled” have ambiguous status; state and federal governments typically consider them to be outside the realm of their responsibility. Nonetheless, their need for services is as great as those of American Indians and Alaska Natives from other settings perhaps greater, considering the few services available to them.

A recent study among American Indians from several Plains tribes found that those who had more positive attitudes toward mental health services were female and those who had greater social support. Those who had negative attitudes were tribal members who were more traditional in their beliefs; those who were older and those who had higher chronic medical conditions. There was a caveat among older adults where with good health insurance tended to have more positive views [72]. While there are glimmers of acceptance and positive attitudes toward mental health services, these appear to be limited and there is much to address before services are adequate, effective, congruent traditionally, and utilized by Indian and Native people in need.

Evaluation-Related Considerations

The limited focus of past evaluation efforts suggests that we must begin to ask a series of broader, more comprehensive questions: (1) What services currently maintain an active program evaluation component? What is this component’s function? How are data collected and used to inform development? How can culturally adapted evidence-based treatments respectfully be evaluated with American Indians and Alaska Natives? (2) What evaluation models are available in general, especially those culturally appropriate for use in certain American Indian and Alaska Native areas? Are there program examples? (3) Are certain types of evaluation more appropriate for one delivery structure than for another? (4) What are the major barriers to program evaluation? How can these be overcome? (5) How does one meaningfully apply evaluation data to program development? (6) What efforts are being made to evaluate the effectiveness of traditional healers in providing services or the effectiveness of collaborative efforts between professionals and healers? (7) What are the competencies required for delivering effective mental health services in American Indian and Alaska Native areas? Must all programs fit the cultural needs of communities? Or must the orientation of the clientele be adjusted to accommodate the limitations of the programs? To what extent are these issues being researched and assessed?

Indigenous mental leaders in policy, practice, and research from Canada, United States, Australia, Samoa, and New Zealand met in 2009 and under the leadership of Sir Mason Durie, Māori professor, founded the Wharerātā Group. This group supports Indigenous leaders working in mental health and addictions and collaborates to integrate best practices for Indigenous people. In the initial meeting, the participants quickly found shared concerns of higher rates of mental illness and inconsistent culturally competent services from mainstream health systems. They issued the Wharerātā Declaration [73].

The Wharerātā Declaration provided five principles foundational to Indigenous health and mental health:

1. Indigeneity, which means the protection and maintenance of cultural knowledge, also known as Indigenous intelligence.
2. Best or Wise Practice, which means that in mental health, Indigenous intelligence is the starting point and mainstream knowledge is added as appropriate.
3. Best or Wise Evidence, which means that evaluation is based on the origin of the intervention; that is, if an intervention is cultural, then the evaluation methodology must be based on cultural knowledge.
4. Indigenous Leadership, which means that although change is needed at a systems level, it must be based on Indigenous intelligence; this means that the Indigenous mental health leader must be:
   - Informed in both cultural and mainstream knowledge and able to switch between the two “languages” to strengthen communication skills
   - Credible with our home community/network as well as with mainstream peers
   - Strategic in thought and leadership to build alliances and partnerships
   - Connected to protect and strengthen networks across sectors including mainstream mental health, Indigenous mental health, political, and funders
   - Self-sustainable as we work to maintain our own work-life balance and to build future leaders to take over for us
5. Indigenous Leadership Influence—use of our positive influence through our networks, with our peers, based on our credibility, is a strategic approach to changing systems to better serve Indigenous clients [73].

Epidemiology

Epidemiological data are requisite to the cost-effective deployment of mental health resources and are especially important when said resources are limited, as is the present case. Several studies report diagnostic distributions and prevalence rates and explore the relationship between psychiatric morbidity and contemporary social pressures [74]. Though open to various methodological criticisms, these kinds of data provide a broader and more divergent picture of the nature and pattern of disorder in American Indian and Alaska Native communities than those that derive from service utilization studies, by far the more common approach to estimating such trends [64, 75].

Epidemiological Considerations

Future epidemiological work among American Indian and Alaska Native communities must address the following questions: (1) To what extent are current diagnostic tools valid and reliable indicators of psychopathology as perceived and experienced by American Indians and Alaska Natives? (2) What is the relationship between “treated” prevalence and incidence rates (derived from service records) and patterns of disorder as manifested in the community at large? (3) Are the data that serve as the basis for “treated” prevalence and incidence rates collected in a reliable, systematic fashion? (4) Can these data be organized, collated, and reported in a regular, relatively current, and accessible form? (5) Can a mechanism be developed to translate such data into meaningful recommendations for the development of mental health services to American Indians and Alaska Natives?

Collecting and Measuring Mental Health Data

In response to the first question, recent studies indicate the methodological and conceptual shortcomings of several diagnostic instruments when administered to members of American Indian and Alaska Native populations. Regardless of the scale of interest, the scores of nonpsychotic depressed American Indian and Alaska Native patients can be indistinguishable from the scores of schizophrenic American Indian and Alaska Native patients [44]. On the basis of these findings, researchers conclude that the similarity of subgroup profiles demonstrates significant cultural influence on the response patterns, rendering the MMPI useless among American Indians and Alaska Natives [60, 76, 77]. Clearly, answers to questions about reliability and validity of diagnostic tools among American Indian and Alaska Native communities await careful studies such as these.

There is little or no indication in the literature as to the relationship between "treated" prevalence and incidence rates and patterns of disorder at the community level in the American Indian and Alaska Native population. No service utilization records were available for comparison among the communities in which epidemiological studies have been conducted previously.

The Indian Health Service collects mental health data systematically across its 12 service unit areas. A computerized patient care information system has been implemented in some of the service areas and, depending upon availability of funds, will be put into effect service-wide in the near future. The protocols for collecting data of this nature have not been examined in terms of inter-rater reliability, which is further complicated by the disparate educational backgrounds and varied training of service providers. Until common valid diagnostic procedures are adopted and the reliability of the collection of patient information is established, this question will also plague future planning and delivery efforts [18].

Health-care planning and policy are monitored by a diverse array of agencies and community organizations: the Indian Health Service and its advisory committees, tribal health departments, the National Indian Health Board and its constituent area offices, the Urban Indian Health Care Association, the Bureau of Indian Education, and the Bureau of Indian Affairs. Some attention needs to be given to how the kinds of data described above can be introduced into such a network to ensure appropriate consideration in the design and modification of mental health services, both those currently delivered and those planned. Successful efforts in this regard will probably prove to have had multiple points of contact with unequivocal relevance and strong community support [39, 78].

Prevention

Prevention approaches, especially those that involve mental health promotion and enhancement, have long held the interest of tribal planners and service providers, the Indian Health Service, local as well as national advisory boards, and American Indian and Alaska Native people. This interest stems from a community-derived sense of self and of others that lends itself to the public health model that underpins the Western health-care system introduced into Indian country through past treaty arrangements [79]. Moreover, Indigenous approaches to health and welfare at the levels of the individual and of the tribe provide fertile ground for the growth of such concepts. Traditional healers, their patients, significant others, social context, and common ethos are intimately linked in an attempt to realize many of the same goals as those expressed in the National Institutes of Health (NIH) prevention policy, specifically family cohesion and positive family relationships; positive well-being, a basic belief in one's self-worth and relative value to the world, however personally defined; respect for others; interpersonal and social skills necessary for effective functioning in society; positive coping capacities and generalized stress resistance; and availability of networks and positive community support systems [64, 78].

Prevention-Related Considerations

In light of the present state of the art, future research on and the delivery of prevention services to American Indian and Alaska Native communities must consider the following questions: (1) What forms of psychopathology are thought to be preventable? By Indigenous means? By nontraditional means? (2) What are the available techniques? (3) How does one appropriately measure outcome? (4) What constitutes effective prevention from a cultural perspective? (5) To what extent and under what conditions are these techniques differentially effective? (6) How can "mental health" be sustained and promoted?

Primary Prevention Efforts

Primary prevention seeks to lower the prevalence of disease by reducing its incidence, which can be accomplished in three ways: health promotion and enhancement, disease/disorder prevention, and health protection. Health promotion and enhancement involve building or augmenting adaptive strengths, coping resources, survival skills, and general health. In addition to focusing upon the capacity to resist stress, health promotion and enhancement require an understanding of the conditions that generate stress and that may affect psychosocial functioning negatively. Disease/disorder prevention encompasses a much narrower spectrum of concerns. It targets a specific disorder and, based on an analysis of risk factors, attempts to manipulate one or more conditions to forestall the occurrence of the disease in question.

In a 2012 review of American Indians and Alaska Natives substance abuse prevention programs conducted by Whitbeck et al. [80] noted rapid development in interventions in the area of substance abuse prevention among American Indian and Alaska Native communities. They review three categories of substance abuse prevention programs including published empirical trials, promising interventions in the process of formal development that have potential for empirical trials, and innovative American Indian and Alaska Native community-driven standardized compilations that may have promise for improvement and wide-scale expansion. The largest, well-regarded randomized controlled, American Indian and Alaska Native substance abuse prevention trial evaluated the universal, school-based adaptation of Botvin's Life Skills Training Program by Schinke et al. [81]. Participants were American Indian elementary students grades 3 through 5 representing 27 elementary schools. The intervention was found to lower rates of alcohol use by 24% and rates of marijuana use by 53% than the control schools. However, American Indian community intervention components exerted no helpful influence on participants' substance use, beyond the impact of skills intervention components alone. The Cherokee Talking Circle, school-based drug prevention curriculum, makes use of the Talking Circle as its primary means of intervention. Using a quasi-experimental design, the Cherokee Talking Circle condition was compared to standard care (i.e., Be a Winner/Drug Abuse Resistance Education) to find that the Talking Circle condition yielded greater increases in self-reliance and decreases in substance abuse/use from baseline to posttest [82]. Further work on the promising programs that have potential for empirical trials needs to be done. Whitbeck et al. [80] contend that it is an arduous task to conduct gold standard trials in American Indians and Alaska Natives communities due to methodological tests in developing and implementing culturally informed prevention efforts (e.g., resistance on the part of many Indians and Natives to scientific methods, challenges in obtaining sufficient sample sizes to detect outcomes, and challenges in generalizability of the findings given the extreme heterogeneity of Indian and Native nations). The current state of the field is promising in terms of range of culturally informed, effective prevention efforts addressing Indian and Native youth alcohol and other drug use and abuse. However, given the paucity of large scale, long-term efficacy studies, it remains challenging for treatment providers to decipher the appropriateness or cost-effectiveness of these interventions.

Early quasi-experimental studies such as the evaluation of the Zuni Life Skills Development Curriculum provided evidence for prevention programs that are grounded in cultural values and perspectives in reducing suicide among American Indian adolescents [83]. A recent quasi-experimental study of the Alaska People Awakening Team's cultural prevention intervention targeting suicide provides a model for prevention intervention research with small sample sizes [84]. The model testing of the Reasons for Life and Reflective Processes conducted by the People Awakening Team supports a potential protective factors model for alcohol abuse and suicide prevention that may generalize to youth from other Alaska Native and other Indigenous groups [85].

Secondary Prevention Efforts

Secondary prevention seeks to reduce the prevalence of disease or disorder through early case finding and treatment. A reduction in the duration of a case consequently decreases the total number of active cases at any given point in time. Manson et al. [86] identified the relationships among psychophysiological symptoms, Indigenous categories of illness, and research diagnostic criteria for depression within a southwestern American Indian tribe, permitting earlier intervention and more appropriate treatment [87]. To our knowledge there have been no evidence-based evaluations of prevention interventions in the area of depression or anxiety with Indian and Native clients. Much like the explication of primary prevention, there are some small-scale efficacy studies to prevent incidence reoccurrence of depression and symptoms of PTSD [88]. More recently there have been a few evidence-based studies of the effectiveness of interventions for American Indian adults with mental and substance use disorders. In a randomized control trial to determine the efficacy of a DWI intervention program with a primarily American Indian sample, participants who received first offender incarceration and a non-confrontational treatment program reported greater reductions in alcohol consumption from baseline levels when compared with participants who were only incarcerated; within this study antisocial personality disorder participants in the treatment condition reported larger effects relative to antisocial personality disorder participants in the control condition [89]. O'Malley et al. [90] studied the efficacy of naltrexone alone and in combination with sertraline in a randomized control trail with Alaska Natives and other Alaskans living in rural settings. They found that naltrexone can be used effectively to treat alcoholism in that setting with evidence of benefit for Indians and Natives.

Cultural Mental Health Practices of American Indians and Alaska Natives

Earlier we discussed the role Indigenous traditional healers can play in the arrangement and delivery of culturally appropriate and sensitive mental health services. Traditional healing systems are important in the treatment of American Indians and Alaska Natives communities. These systems focus on balancing mind, body, and spirit via a connection with place and land [30]. Some American Indian and Alaska Native populations believe that traditional-based healing practices have potential to help address mental health-care needs within their communities. Research shows that Indigenous men and women who meet criteria for depression/anxiety or substance use disorder are significantly more likely to seek help from traditional/spiritual healers than from other sources [15, 16].

Protective factors are concepts that are key to the "cultural context, identity, adaptability, and perseverance" of American Indians and Alaska Natives. The factors include holistic approaches to life, a desire to promote the well-being of the group, an enduring spirit, and respect for all ways of healing [17, 18]. Strengths and protective factors common to North America's Indigenous communities include a strong identification with culture, strong family ties, enduring spirit (persistent, embracing the future, forward thinking), connection with the past, traditional health practices (e.g., ceremonies), adaptability (flexible), and the wisdom of elders (respect for knowledge shared and knowledge earned).

As we have indicated in several sections of this chapter, there is an abundance of evidence that exists that illustrates the difficulties experienced by practitioners in delivering mental health services to American Indian communities [91–94]. While never quite empirically documented, one of the major problem sources could well be the way mental health, in all its facets, is conceptualized by many American Indians and Alaska Natives. For numerous North American Indigenous groups, thoughts, beliefs, ceremonial practices, and traditions, among other ways of thinking and living, are holistic. States of mind and body, social roles, family and community organization, and the like are functionally interrelated and virtually inseparable. "Mental," "mind," "personality," and "self," for example, have unique organizing qualities within the Native view. For this reason, many traditional Native people experience difficulty coming up with conceptually equivalent mental health terms in their own native languages. American Indians and Alaska Natives, like all other linguistic groups, developed unique systems for "classifying and categorizing forms of behavior {that} fit closely within their world view and the view they have of themselves as people" [91, p. 14].

In the Lakota language, for example, "mental health" translates as *ta-un* (*being* in a state of well-being, *not a state* of well-being). *Ta-un* is a state of being that allows certain kinds of behavior to occur. One's *ta-un* is rarely, if ever, questioned; in fact, it's almost unthinkable to ask someone to elaborate on the state. For that matter, within many segments of the Lakota reservations, it's considered rude to inquire about a person's psychological well-being, no matter what the state of may appear to be [91]. While the concept of attaining personal insight is important to many mental health intervention programs, it could also be another source of difficulty for those working with traditional American Indians and Alaska Natives clients. In many American Indians and Alaska Natives community's self-reflection is just not taught, revered, or in any way expected of an individual. Certainly, there are ceremonial occasions in many communities where one reveals the content of dreams or vision quests and the interpretation and analysis, revered or in any way expected of an individual.

Mental health and all of its aspects can and probably does mean quite different things to many American Indians and Alaska Natives. And the implication that mental health is grounded in different ways in the value and belief systems of one's cultural group gives rise to serious questions for cross-cultural studies of American Indian and Alaska Native mental health. The efficacy of past mental health research efforts must be assessed with this implication in mind.

Numerous American Indian and Alaska Native mental health practitioners and scholars maintain that American Indians and Alaska Natives believe that individuals choose their state of wellness. If one stays in harmony with all that embraces them and follows all the tribal and sacred laws, one's spirit will be strong, and thus negativity will be unable to influence it. If harmony is broken, the spiritual self is weakened, and one becomes vulnerable to physical illness, mental and/or emotional upsets and the disharmony projected by others. The "path" or "way of living" provides the individual with traditionally grounded directions and guidelines for living a life free of emotional turmoil, confusion, animosity, unhappiness, poor health, and conflict-ridden interpersonal and intergroup relations.

American Indian and Alaska Native tribes and villages developed and maintained sophisticated and elaborate systems or collections of principles, beliefs, or practices that guided individuals along the straight path. Healing practices also were well established to assist individuals who strayed from the "straight path." Shaman or traditional healers were delegated or inherited by birthright the responsibility to conduct healing ceremonies, and healing traditions were handed down from one generation to the next following highly regulated rites of transmission, passage, and protocol. Healing practices as well as the specifics concerning the "ways of living" no doubt varied considerably from one tribe or village to another. Moreover, many of these practices likely changed over the centuries through exchanges of practices, rituals, and ceremonies generated by contact with other groups and new insights gained by healers through personal and spiritual experiences. Traditional "ways of living" continue to be endorsed and practiced by most North American Indians and Alaska Natives, although some vary considerably from the ways they were practiced and carried out centuries ago.

Noisy Hawk and Trimble [95] maintain that traditional Lakota's, well-being (wicozani) is a psychological state of being at peace and harmony (wolakota) with oneself and with all of creation (mitakuye oyasin); the good happy life [96]. The lack of harmony and well-being or lack of success in American Indians and Alaska Natives counseling strategies could be improved by more research to discern how American Indians and Alaska Natives conceptualize and process cultural determinants of psychological illness and wellness and by incorporating aspects of the traditional understanding, such as the Lakota path to well-being. Well-being for American Indians and Alaska Natives should be strengthened by providing a cultural context for healing programs and research that incorporates and emphasizes the importance of language, mythology, and ritual. Those components of a culturally specific context mediate the self-identification of the path to healing/well-being. Many American Indians and Alaska Natives traditional healers have identified well-being as the result of living in context with cultural laws, family, and the tribe [97].

For modern observers to assume or claim that mental health healing practices are new to American Indians and Alaska Natives would be presumptuous. In one form or another, healing those who stray from the straight path has always been a part of the holistic fabric of the lifeways and thoughtways of Indigenous peoples. Most American Indians and Alaska Natives know something about contemporary versions of these practices. However, not all American Indians and Alaska Natives choose or have the opportunity to participate in them, owing to a number of factors, including orthodox religious convictions (or conversion) marked by conformity to doctrines or practices held as right or true by some authority, standard, or tradition; geographic distance of traditional healers from their home villages or communities; distrust of traditional healers and their practices; lack of access to traditional healers, especially in urban settings; lack of awareness of the presence and effectiveness of traditional practices; and confusion concerning the choice between traditional healing and use of mental health counselors and clinicians.

Reasons vary from one individual to another. For those who choose not to seek the services of traditional Native healers, the only available alternative is to seek the assistance of professionals in the conventional mental health fields; that choice, too, can be compounded by numerous factors, including distrust, misunderstanding, apprehension, and the real possibility that mental health practitioners may be insensitive to the cultural backgrounds, worldviews, and historical experiences of American Indians and Alaska Natives clients. The main issues for these clients are concerns that their "presenting problems" may be distorted by the results of psychological tests that are incongruent with their cultural worldviews and that professionals may arrive at clinical diagnoses grounded in psychological theories that do not value and consider culturally unique perspectives.

Summary and Conclusion

There have been several national task forces that have specifically addressed the mental health of American Indians and Alaska Natives. Among them are the President's Commission on Mental Health (PCMH) in 1978; Manson's [75] supplemental report of the US Surgeon General; and the 2011 report by the Office of the Inspector General. Many of the questions posed in this article echo the recommendations of those reports. Those recommendations note that "at present services and service delivery systems to (American Indian and Alaska Native) people ... are disjointed, disorganized, wasteful, fragmented, and counterproductive" [88, p. 982] and call for an examination of ways in which to coordinate the delivery of mental health care more effectively.

Concern is expressed over the lack of knowledge about the relative efficacy of non-Indigenous forms of counseling and psychotherapy with American Indians and Alaska Natives and about mechanisms to enhance and support traditional native practices. Thorough and ongoing program evaluation is set forth as the cornerstone for eliminating duplication of services, for achieving greater institutional accountability, and for increasing awareness of successful, appropriate methods of care. The lack of a solid epidemiological database is recognized, as is the cultural bias of diagnostic instrumentation. Mental illness prevention is frequently cited in the context of the chronic physical ailments that plague American Indians and Alaska Natives; mental health promotion is held out as a possible and desired function of schools serving American Indian and Alaska Native youth. Basic and applied research on the full range of phenomena associated with these aspects of service is a common theme across all the recommendations.

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9

Mental Health of Arab Americans: Cultural Considerations for Excellence of Care

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Introduction

The Middle East is a geographical location spreading between Southwest Asia, North Africa, and Europe. With the exception of Iran and Israel, the countries forming this region are all Arab and are frequently referred to as the "Arab world." The Arab world is comprised of 22 countries including Iraq, Syria, Lebanon, Jordan, the West Bank and occupied territories (Palestine), and all the Gulf states. In addition, it extends through North Africa to Egypt, Algeria, Tunisia, Morocco, Libya as well as Sudan and parts of Mauritania.

Arab countries are diverse in size, political systems, and religions. Contrary to a common misperception, being Arab is not synonymous to being Muslim. Rather, there are Arabs who are not Muslim (such as some Lebanese, Syrians, Iraqis, Jordanians, Palestinians, or Arabs from North African countries), and there are Muslims who are not Arabs (such as Turks and Pakistanis).

Immigrants from the Middle East constitute the highest proportion of migrants worldwide [1]. Immigrants also include refugees who were forced to leave their country in order to escape war, persecution, or natural disaster. Despite their significant racial and ethnic heterogeneity, these immigrants may share a similar experience of migration and acculturation process when they arrive to the United States. The first wave of immigrants primarily left their countries in search of education, economic opportunities, and freedom. More recently and with an increased numbers of refugees, they are seen fleeing political oppression and war.

Arab individuals share multiple similarities though they may differ in their origin: Semite people (descendants of Abraham), Shami people (Lebanon, Syria, Jordan, and Palestine), Arabs from the Gulf states (United Arab Emirates, Kuwait, Yemen, Bahrain, and Saudi Arabia) or North African Arabs. Intra-ethnic diversity covers a spectrum from the most religious to the most secular and political systems of governance vary between democratic, monarchal, dictatorial, or tribal. Even though language is the main commonality between the different Arab populations, it is not the only one. They share common food, music, literature, holidays, traditional events, and political histories [2]. Despite receiving significant public

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attention since the September 11, 2001 terrorist attacks on the United States (9/11), Middle Eastern populations remain a poorly understood group. Many Americans may only be informed about the Middle Eastern culture through public media [3–5].

The interaction between an individual's and a provider's cultural background plays a major role in the patient's symptom expression and adherence to treatment [6]. Mental health services in the United States are frequently underutilized by immigrant populations [7–9]. This is partly caused by a lack of cultural sensitivity toward the patient [2, 10]. Professionals working with people of Arab origins may find only limited data to guide their understanding and treatment of the mental health problems of this population [11, 12]. Empirical research addressing the mental health of Arab Americans has been largely explorative in nature and remains negligible compared to that involving other US minority groups [1, 13]. A deficient understanding of the cultural and mental health correlates of this population may push professionals to rely on the only other available information source that is mainstream politicized media [14]. This is especially true given the increased discrimination this community was subjected to after 9/11 [15]. As a result, these professionals are predisposed not only to stereotyping and prejudice but also to inaccurate diagnosis and treatment [14].

This chapter aims to provide clinicians, educators, and professionals with a better understanding of this community. It begins with a sociodemographic overview of Arab Americans and their immigration patterns followed by a review of the characteristics of their mental health. It then presents the cultural considerations pertinent to a culturally sensitive understanding of this population. Blended case vignettes are used to illustrate the cultural complexity encountered in the clinical setting. Finally, the chapter concludes with clinical recommendations to the professional treating Arab Americans. It is hoped that this body of work can in itself foster cultural sensitivity in clinicians and professionals who are not Arab or Middle Eastern and, by the same token, shed some light on the many challenges such work poses to the professional of similar background as well. It is also vital for mental health professionals to acknowledge the many overlapping identities of a single individual and the impact on psychological functioning and navigation of the social and political world. The intersections of race, culture, gender, religion, and sexual identity are discussed throughout with awareness of how this can influence the Arab American experience of discrimination and oppression.

Arab Americans

Social Demographics

Data collected for the 2010 US Census estimate the number of Arab Americans to be around 1.9 million people. This number is likely to be inaccurate due to significant underreporting. Arab Americans have often been designated as an "invisible minority." Identification biases occur when Arab Americans identify themselves as Middle Eastern or as Caucasian, thus leading to difficulty in estimating their exact numbers. This is interpreted to be partly caused by fear of misperception or distrust in surveys [16]. The Arab American Institute generates a number closer to 3.6 million when accounting for such underreporting errors [17] (Table 9.1). Approximately two-thirds of Arab Americans were born in the United States, and around 82% of them are US citizens [12]. When the US Census started collecting data related to Arab ancestry in 1980, the number of Arab Americans in the United States had grown by more than 70% by 2010 [17]. Arab Americans are distributed all over the United States, but the majority live in one of these ten states: California, Michigan, New York, Texas, New Jersey, Illinois, Ohio, Pennsylvania, Virginia, and Florida. About one-third of this population settled in metropolitan cities of Detroit, Los Angeles, and New York.

The majority of the Arab American community claim Lebanese or Syrian origins [17].

Table 9.1 Demographic description of Arab Americans

Ancestry	Population	Percent of Arab American population	Percent of US population
Arab countries			
Overall Arab	1,646,371[a]	100	0.53
Egyptian	190,078	11.55	0.06
Jordanian	61,664	3.75	0.02
Iraqi	105,981	6.44	0.03
Lebanese	501,988	30.51	0.16
Moroccan	82,073	4.99	0.03
Palestinian	93,438	5.68	0.03
Arab[a]	290,893	17.67	0.09
Other Arab	223,020	13.55	0.07
United States, overall	*309,349,689*		

Source: American Community Survey (2010) (US Census Bureau)

[a] Individuals who marked their ancestry as Arab without specifying a country of origin

However, immigrants originating from Egypt and Iraq have witnessed the sharpest increase in number since 1990 [17]. Further data about specific ancestry may be missing as many census respondents (approximately 17%) mark the general category of "Arab" or "Arabic" to describe their roots [17]. Between half to two-thirds of Arab Americans self-identify as Christians (Roman Catholic, Eastern Orthodox, and Protestant in descending order); the rest are Muslims in majority [1, 18]. However, in recent years, Arab Muslims became one of the most rapidly growing populations in the United States [1]. This is due in part to the United States Refugee Admissions Program (USRAP). Since 2007, USRAP has helped with resettling more than 60,000 Iraqi refugees in to the United States [1]. In the United States, Islam ranks as the second religion in number and as the fastest growing religion in the country [19] and in the world with around 1.57 billion believers [20]. The number of Muslims in the United States is estimated to be around 7–10 million [19].

In 2011, Arab Americans were found to be comparatively younger, wealthier, and more educated than the national average [1]. The majority are entrepreneurs and owners of businesses [14]. Newly arriving Arab immigrants and refugees leaving war-torn areas of the Middle East generally have a lower socioeconomic status. Many of them are living below the poverty line, tend to have a lower level of education, and do not speak English [1].

Arab Immigration Patterns to the United States

The migration patterns of Arab populations to the United States are historically divided into three phases referred to as "waves of immigration." These waves differ from one another in historical and political circumstances, demographic distribution, and the acculturation processes of the immigrants [12]. The first wave started around 1875 and lasted until World War I. The majority of these immigrants originated from Syria and Lebanon. They were mostly Christians who worked in farming and trade and left their countries under the pressure of economic hardship [21].

The second wave spread between 1948, the year the state of Israel was established, and the 1967 War between the Arabs and Israel. As compared to the first wave of immigrants, this group was more educated, spoke English more fluently, and pursued higher education and professional occupations. The second wave immigrants left their countries at a time when the Arab world was gaining its freedom from the European colonies and were more attached to their Arab identity [12, 22, 23]. Demographically, this wave had a higher proportion of Muslims than the first wave [11]. During these first two waves, Arab immigrants settled in the Northeast and Midwestern cities like Chicago (Illinois), Dearborn and Detroit (Michigan), and Toledo (Ohio) [24].

A third wave of Arabs started migrating to the United States after 1967 and continues until the present day. This wave is largely comprised of Muslim Arabs and is characterized by a diverse mix of educational and socioeconomic levels [14]. The vast majority are fleeing war or unstable political conditions and are looking for economic opportunities [12, 23]. During the 1990s, the number of Arab immigrants from North Africa and the Gulf states grew significantly [21, 25–27]. Multiple waves of Iraqi refugees migrated during and after the Gulf War of 1991 [28]. These refugees settled mostly in the metropolitan Detroit area of Michigan where a large Arab community was already established [29].

In Arab countries with devastating war conflict such as Syria and Yemen, migration to the United States has drastically increased since 2010. The United States resettled more than 18,000 Syrian refugees since the start of the Syrian Civil War in 2011. Acceptance of Yemeni refugees has been much lower with just over 60 refugees accepted between 2011 and 2016 [30]. At the start of 2017, rates of immigration from the Middle East and North Africa shifted when the Trump administration enacted sweeping policy change, including a temporary sanction that disallowed individuals from Iran, Libya, Somalia, Sudan, Syria, and Yemen from entering the United States [31]. The ceiling for refugee admissions was also dropped from 110,000 to 50,000 in 2017. Overall, approximately 54,000 refugees from all countries were resettled in the United States in 2017, compared to 86,000 in 2016. Syrian refugee resettlements decreased from 15,500 in 2016 to approximately 3000 in 2017, a near 80% reduction [32].

Mental Health of Arab Americans

Research

Empirical research on the status of Arab American mental health remains minimal. Studies examining the mental health of minorities rarely include Arab Americans as a subgroup [13, 29, 33]. Most available studies have been conducted by colleagues in the fields of sociology, nursing, and anthropology [14]. These studies identify important basic sociodemographic characteristics of the populations but are largely qualitative in nature or based on small sample surveys [13, 14]. Most studies continue to investigate these characteristics in community settings and in chronic diseases (e.g., hypertension, diabetes mellitus, and heart disease) [19, 34]. Limited research on this population constitutes a major hindrance for a provider's ability to meet its rising mental health needs [35].

Only few clinical studies have examined risk factors and the mental health concerns of Arab Americans, especially in the period following 9/11 [13]. One study identified increased rates of depression and posttraumatic stress disorder (PTSD) among Arab Americans as compared to the community [36]. Another study involving a sample of Muslim Americans, among which 44% were of Arab origins, documented an association between perceived religious discrimination and subclinical paranoia [37]. A study by Amer and Hovey showed that Arab Americans display higher rates of anxiety and depression compared to nonclinical community samples (normative samples) (pp. 409–418) [13]. Another study examining suicide among Arab Americans living in Michigan (MI) found lower suicide rates among this population when compared to non-ethnic Whites, regardless of gender [15]. Arab Americans in Wayne County, MI, where the largest Arab community resides, also had lower suicide rates than Arab Americans outside of this county [15]. These outcomes parallel findings among other ethnic minorities, where a collective mentality, familial and cultural social bonds, and group and community identity are strong protective factors against suicide [15].

Many factors likely attribute to the small amount of research within the Arab American population. Arab Americans, frequently referred to as an "invisible minority," are often merged in public surveys with "White" or "Caucasian," and many may refrain from identifying themselves as Arabs [13]. In conducting research studies, this can prohibit appropriate random sampling from public mental health databases [13]. Furthermore, the dispersion of this population and their small numbers in certain states makes it hard to reach sufficient samples for such studies [13]. Another major factor is a common aversion among Arabs to written surveys due to a mistrust of research and its purposes [14, 16]. In addition, many research tools and measurement scales lack cultural sensitivity and validity for the Arab American population, presenting another major obstacle for obtaining reliable outcomes [13]. Finally, mental health symptoms in Arab Americans may be disguised under somatic complaints and when acknowledged as psychiatric symptoms (e.g., depression) may be defined differently, rendering the task of researchers more challenging [28].

Cultural Display of Symptoms

Case Vignette 1

55-Year-Old Female With Paroxysmal Episodes of Body Shaking

Rania, a 55-year-old Egyptian female, migrated to the United States 6 years ago with hopes of ensuring a better future for her children. She married her husband, 20 years older than her, in her late 20s. He remained in Egypt. They had five children. Four of them were already studying in American colleges and one teenage daughter was still living at home. Rania had studied to be an engineer in Egypt, but her degree did not allow her to work in the United States.

Rania was first brought to an Emergency Department (ED) by her eldest son for concerns about sudden-onset episodes of body shaking and severe weakness that at times she could not stand up. She often experienced intense fear that these episodes would occur while in public. These periods of weakness and fear resulted in multiple visits to the ED, where all cardiac and neurological testing revealed no abnormalities. She had no psychiatric or neurological history prior to visiting the psychiatric clinic. Her symptoms had been occurring over a period of 6 months after which it was concluded that she be referred to a mental health professional.

After much resistance to the idea, Rania started treatment with at an outpatient psychiatric clinic. She was on time to each of her appointments and always dressed in traditional Muslim clothing, including the *hijab*. Initially, she displayed significant preoccupation with her health and required frequent reassurance. Early sessions stressed the connection between her physical symptoms and feelings of anxiety. Over the next few months of her treatment, Rania shared more information about her cultural background and family. She expressed frustration with her teenage daughter, who liked to listen to American music, refused to do her chores, and insisted on going out every day. She also talked about the lack of intimacy with her husband. She described him as a kind and supportive man, yet felt rejected by him, as he would visit her only after an episode. Rania discussed feelings of loneliness, her family of origin, the growing independence of her children, and the advice of her local Egyptian community to stay at home more often.

As psychotherapy progressed, Rania acknowledged her anxiety and depression but refused to take psychotropic medications. Her treatment consisted mainly of cognitive behavioral modalities to identify her anxiety triggers. She was also introduced to relaxation techniques and cognitive restructuring to help her divert her attention from negative thoughts. With time, Rania was able to speak more openly about her feelings and her episodes began to lessen. She joined a vocational rehabilitation program to prepare her for work in the community. She began taking classes at the local university and joined a gym. She had 1 year free of any episodes or anxiety symptoms until the 2013 Boston Marathon bombing. This triggered daily panic attacks. She collapsed while at the gym, and she had to be transported to the ED, where the medical work-up was once again negative. In session, Rania verbalized fear of discrimination as a Muslim woman wearing a head veil. She also feared that her college-age daughter, who also wore a headscarf, would be assaulted on campus. She felt people were looking at her in a "funny way" and suffered from disrupted sleep. As a result, her therapy sessions were increased to biweekly appointments to continue to address her recurring anxiety symptoms. She established a new goal of traveling to Cairo in the fall to visit her sisters and finish her vocational rehabilitation program. (end of case vignette 1).

Immigrants' perceptions of their experience and adjustment to illness depend on their cultural view of disease and their expectations of health services [3]. An Arab American patient may display psychiatric symptoms differently than a Western patient. Arab Americans tend to express psychological pain through physical symptoms or by using somatic terminology [38] like Rania in the above case. A fatalistic worldview predominates the cultural thinking with a significant reliance on God's will exemplified by the famous *insha'Allah* (God willing) [39]. In addition, many regard envy or "the evil eye," referred to as *hasad* in Arabic, as a main cause of ailment [1]. This concept may be mistakenly understood as a delusion of persecution in Western culture.

The application of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5) criteria and its subsection on culturally bound syndromes, is often not readily applicable to Arab Americans [40]. Clinicians report a high frequency of somatic symptoms in this population. Reporting physical complaint as a substitute for low mood or anxiety symptoms may be due in part to stigma and shame associated with having a psychiatric diagnosis [29]. In addition, it may be that the Arabic language allows for a different description of pain and makes a clear distinction between physical and psychological pain [41].

These factors emphasize the challenges mental health professionals may face when attempting to understand symptoms using the DSM-5 [40]. For instance, when it comes to mood disorders, Arab American patients often perceive them as physical in nature. Negative feelings and internal or external conflicts are not expressed with much ease. Instead, somatic symptoms are the more acceptable form of expression. Anxiety or depression may be expressed as gastrointestinal complaints, bodily pain, or fatigue [38]. They can be expressed as "thinking too much" [11] or a sense of chest oppression or shortness of breath [42]. In addition, given the religious prohibition of suicide in traditional Middle Eastern cultures (both Christian and Muslim denominations), and for fear of being refused burial, patients may refrain from sharing suicidal ideation with the mental health provider [40]. Another obstacle to symptom disclosure is that many Arab Americans consider the discussion of family matters with a stranger (i.e., the provider) a cultural taboo [40]. They may refuse to answer probing questions or simply dismiss discomforting topics as normal. Along the same logic, religious teachings forbidding gender interaction (in Islam) and premarital sexual intercourse may prevent the patient from admitting to an active sexual history or sexual assault [40]. In the Arab culture, the concept of "bizarre" that applies to certain psychotic symptoms may be different from what Western providers are familiar with. For example, psychotic delusions may frequently be expressed in religious or political contexts pertaining to the native country. Differentiating between delusional thought content and non-delusional cultural beliefs is critical in avoiding misdiagnoses. Negative symptoms of schizophrenia could easily be misinterpreted as a deficit in English language proficiency. As a result, when attempting to diagnose psychiatric disorders in Arab Americans, familiarity with the patient's culture and country of origin as well as culturally sensitive and Arabic-proficient interpreters prove critical in arriving at the correct diagnosis and treatment recommendations.

Alternative Cultural Practice, Traditional Healers

In Arab societies, traditional healing is used in parallel or at times before accessing mental health services [11]. These methods are viewed as complimentary rather than oppositional. Hence, it is not unusual for the individual to seek both types of treatment simultaneously [11].

By definition, the traditional healer or *Hakim* (Arabic for "wise") emphasizes the spiritual-mental portion of treatment. Typically a male, he is regarded as an authoritarian figure whose presence is central to the treatment and healing process. He guides, instructs, and provides the patient with a treatment plan and may suggest ritualistic techniques, such as burning incense or visiting the tombs of saints [11]. The traditional healer is also seen as a father figure who provides support and validation [11] and maintains a close connection with the patient. Contrary to modern mental health services, which may lack collaboration with the patient's family [43], traditional healers actively engage the family. They identify and include a member who holds a dominant presence in the patient's family to facilitate the process of treatment and the recruitment of family and community resources in that process [11].

In addition, traditional healers also exist in the Islamic religion. For Muslim Arab Americans, this approach is sometimes used at least in the primary phase of treatment. Few commonly used figures are *the Katib*, *the Moalj belKoran, and the Dervish*, who aim to deflect evil spirits or prevent illness. The *Katib*, also referred to as *Hajjab* who is a typically a male, creates amulets for the patients to wear on their body. The *Moalj belKoran* (*or the healer through Koran*), also a male, uses the Koran and Islamic scripture [44, 45]. The *dervish* can be a male or a female and uses cultural or religious techniques for the treatment of mental illness [11].

The use of traditional healers by Arab Americans remains the exception rather than the rule. Most Arab Americans from various religious backgrounds rely more on Western medical approaches as a first line of treatment, even in cases where the expression of symptoms is primitive such as acting out or through somatization.

When working with Arab Americans, healthcare providers and especially mental health professionals should become familiar with the role of traditional healers in the treatment process, in the recovery period, and in the pursuit of well-being. The traditional healer shares a similar background with the patient and hence a relatively closer worldview and can assist as an important facilitator of the patient's grasp of their problem, its sources, and appropriate ways to manage it [11].

Underutilization of Mental Health Resources

The utilization of mental health services by immigrants may be significantly affected by cultural and immigration-related issues [7–9]. Of note, the trauma-related history of most refugees resettled in the United States makes utilization of mental health services even more problematic. These patients may show up to emergency wards with somatic complaints rather than mental health symptoms and may not share their traumatic experiences. The younger generation of refugees may be more likely to recount what they witnessed, and their trauma issues may be dealt with in the offices of mental health professionals or captured by mental health services and community resources.

Underutilization of psychiatric resources and services may exist in Arab Americans to the same extent it does in the Arab world [11, 46]. Multiple factors may be responsible for such reluctance. Arab Americans, similar to other non-Western cultures, often perceive mental health services as stigmatizing [47]. Seeking psychiatric care is a last resort. Stigma causes significant emotional distress to the patient who may fear being labeled as "crazy" (*majnun* in Arabic) if they sought mental health assistance [38]. The notion of "lunatic house" or "nut house" is pervasive. In addition, Arab Americans may have a general disbelief in the benefits of mental health services. Even after agreeing that it is needed, the patient often comes unprepared to their psychiatric encounter. This understanding differs among the diverse immigrant populations depending on their cultural backgrounds and the availability of mental health services in their native country [3]. A shortage in mental health services in the country of origin can result in a deficient perception of the need to seek professional help [3].

A major hindrance to seeking help comes from the discomfort an Arab American may have with discussing personal issues or feelings of weakness with a non-family member [12]. This may also be due to the threat such an act can pose to the person's sense of loyalty or the dishonor it may bring to the patient's family [48]. Instead of seeking professional help, an Arab American may seek psychological comfort from a family member, typically of the same gender [3]. This tendency is augmented by a general distrust of non-Arab health providers although it could be seen for the same reasons with Arab-speaking providers as well [12].

A general unfamiliarity with Western psychological models and ways to access such services may be prevalent among Arab Americans [3]. Arab Americans expect mental health treatment to be timely, structured, and directive with minimal participation on their part, similar to medical treatments [11]. They prefer a quick fix and may often expect a "cure" without sharing much personal information [11]. Kulwicki explained this phenomenon: "Arab-American clients often expect doctors to make medical decisions without the need for the collection of a medical history and without consultation with the clients. In cases where the clients are asked to participate in decision making about their medical regimen, they may lose trust in the medical experts and discontinue treatment" (p. 201) [11]. When added to the cost of services, the lack of insurance coverage, and little awareness of community mental health care clinics, these factors lower the probability of Arab Americans utilizing mental health services they may need [3]. In addition, Arab Americans may assume that invasive methods of treatment such as injections or surgeries are more effective or potent than other treatments. Hence, Arab Americans may see treatment modalities such as occupational therapy or physical therapy as ineffective. This may be even more of a problem in the case of psychiatric or psychological treatments when "talk" therapy is initiated and no hands-on treatment is perceived.

Language barriers constitute another significant obstacle [1]. In the absence of Arabic-speaking health professionals, interpreters, or Arabic-language health materials, accurate symptom description is limited. As a result, the creation, discussion, and implementation of a treatment plan may become difficult [1]. The need for Arabic-language medical interpreters, health education aids, and culturally sensitive services cannot be stressed enough.

As for inpatient hospital stays, the Arab patient may become uncomfortable or even agitated in wards where men and women share hallways or units in the hospital. Hence, the treatment plan should reflect such dynamics.

After the events of 9/11, an added barrier to medical care surfaced among some Arabs in the United States [1]. The mistrust in government agencies and fear of deportation may have spread to the field of healthcare where some Arab immigrants would stay away from any public service that could be connected to the US government [1]. The recent US travel ban on certain Muslim countries may also negatively affect the likelihood of Arab Americans to present to medical care due to fear of deportation. Many may prefer to discuss their health issues verbally and may avoid filling out intake forms for fear that this information could be used against them [19]. Arab American patients may be more likely to seek mental health services if offered reassurance about the confidentiality binding their relationship with the provider and the validation of their experience [24].

The Case of Iraqi Refugees in the United States

Case Vignettes 2

45-Year-Old Iraqi Male With Posttraumatic Stress Disorder

Khalil is a 45-year-old Iraqi man who was referred by his previous provider to see an Arabic-speaking male psychiatrist. He migrated to the United States as a refugee from Iraq in 2005 and currently lives with his wife, two children, and his parents in a city with a large Arab community. He had attended only a few sessions with his previous psychiatrist after which he started missing his appointments repetitively. He had requested to see a male mental health professional as he felt embarrassed to share his full story with a female provider.

During the initial assessment, Khalil stated that he was considered by his family to be "weak" for consulting a mental health professional. He was unemployed and had trouble finding a job. Prior to his migration to the United States, he worked as an accountant in a governmental organization. His family, who always accompanied him to his appointments, corroborated a history of physical torture and multiple traumatic events experienced during the Gulf War including witnessing his brother dying in a car explosion. Khalil's parents reported that he has been staying at home and not interacting much with them or Arab friends. In Iraq, he had been to multiple traditional healers with no benefit. He had also worked with the Imam in their community, which helped only minimally. This led to his first referral to a psychiatrist.

In the first phase of treatment with the psychiatrist, much time was spent on strengthening the therapeutic alliance and a trusting relationship with Khalil and his family. In the following sessions, Khalil was gently encouraged to elaborate on his traumatic experiences, and more symptoms were identified, leading to a diagnosis of posttraumatic stress disorder (PTSD).

After an initial refusal to take psychotropic medications, Khalil eventually accepted this option after consulting with his parents and other family members. Over the following months, he reported improvement in his symptoms. He started leaving his house more often and interacting with Arab friends in his community. After 8 months of therapy, he began to work as an Arab language teacher for some of the children of Arab American friends and took English language lessons.

During the sessions, open-ended questions were used and medical jargon was avoided. Khalil was given ample time to answer. His parents were invited to the sessions on a regular basis. His migration-related challenges and political views were explored.

Three years later, Khalil continues to report improvement in his PTSD symptoms. He has become more proficient in English and is seeking another job. His father started seeing an Arab colleague psychiatrist for similar problems. (end of case vignette 2).

Multiple pre-migration and post-migration stressors play a role in the heightened stress and resulting medical and psychiatric morbidity [29]. The mental health of immigrants is heavily influenced by these stressors [49]. Loss and traumatic exposure preceding migration represent a risk to the development of mental health difficulties, and both predict difficulties with adjustment [3]. This is especially true for refugees, like Khalil in the above case vignette, whose migration was forced by war, torture, and persecution [7]. Emotional hardship in immigrants was found to be significantly predicted by prior trauma, torture, pain, lower educational levels, a poor social network, and unemployment [50]. When compared to citizens of the country of resettlement, refugees are found to be ten times more likely to develop PTSD [51]. In the post-migration stage, mental health difficulties of immigrants have been found to be associated with poor knowledge of the English language, lower socioeconomic level, and poor grasp of the new societal norms [49]. Furthermore, this population has additional burdens that prevent their access to healthcare among which are the lack of health insurance, working in poorly reimbursed jobs, and the absence of financial support for medical expenses [1].

Few clinical studies have examined the mental health of Iraqi refugees. Iraqi immigrants express a different pattern of medical and psychiatric illness compared to other Arab Americans [29]. They are more likely to have general health issues when compared to other Arab subgroups [29], in addition to a higher prevalence of PTSD, anxiety, and depression [52]. Substance use disorders (SUD) are relatively elevated in this population despite their relative rare occurrence in individuals of Arab origins [29]. The wave of Iraqi refugees who arrived to the United States in the early 1990s had significant wartime traumatic exposures from the Iraq-Iran War in the 1980s and the Gulf War of 1991 [29]. Many of these refugees suffered exposure to combat, unsanitary refugee camps, nutritional deprivation, and lack of clean water. Others have experienced multiple separations or losses, and some have witnessed the death and maltreatment of their close relatives or friends [29]. Others were themselves victims of torture. Since 2007, the US Refugee Admissions Program (USRAP) has helped with resettling more than 60,000 Iraqi refugees into the United States [1]. Resettlement to Michigan was officially halted by USRAP following the decline in its automobile-based economy [1]. As a result, this population experienced a significant rise in unemployment rates reaching three times the national average, and many refugees were reported to leave the United States to other countries [1]. The impact that these factors have on the mental health of Iraqi refugees and that of the process of acculturation necessitate additional research [29].

Cultural Considerations in the Mental Health of Arab Americans

A cultural mental health formulation necessitates a thorough assessment of the cultural values of the individual, their religious beliefs, and the circumstances surrounding their migration and acculturation to the new society [11, 12, 14, 48, 53, 54]. There has been a recent increase in the body of literature by both Arab and non-Arab authors covering the issue of cultural sensitivity when treating people of Arab origin [11, 55]. Some authors have shed light on the extent of applicability of Western psychiatric methods and concepts of mental illness on minority populations in general and women in particular [56]. Individual dynamics are connected to sociopolitical and cultural contexts, and the level of acculturation can be very different even between members of the same family [56, 57]. Family and couple's dynamics may mirror government and political regime problems. For example, violence may trickle down from authoritarian regimes to family, head of households, and couple's dynamics in certain populations [58]. Health professionals caution that Arab patients may only be fully understood if these contexts are considered.

Language

Arabic is the spoken language and is considered the official language of all 22 Arabic countries. Arabic ranks fourth among the most widely spoken languages of the world [18]. Multiple dialects exist in the Arabic language, and they differ vastly from one another and from formal or classical Arabic [59]. Classical Arabic is the written version of the language and is uniform across all countries [18]. In the Arabic language, the content is as important as the tonality. For example, to emphasize something or express a feeling, Arabs may use repetitions, metaphors, exaggeration, euphemisms, and even threats (when angry) [18]. Most of the newly arriving Arab immigrants and especially refugees speak Arabic only or are not proficient in English [1]. This was found to be the case in refugee women who frequently had less education than men in their native country [1].

Verbal communication plays a vital role in achieving a successful therapeutic relationship. The language barrier is one stressful element to overcome in the acculturation process. It governs well-being. It can also impede access to optimal medical care [1] due to the deficit in communication between the patients and their providers. The lack of proficiency in English in Arab immigrants may hinder their description of symptoms or their understanding of their treatment recommendations potentially leading to suboptimal treatment [1]. The availability of medical interpreters and Arabic-speaking providers is not always an option. As a result, many of the Arab patients rely on relatives or friends for translation [1], which can have significant drawbacks given the potential for family and control dynamics to interfere with the accuracy of translation or simply the lack of medical knowledge of these substitute interpreters.

Given the importance of language in the therapeutic intervention in mental health, the access to certified interpreter services or mental health providers who speak the immigrant's language is of prime importance in the provision of culturally sensitive services to Arab immigrants [1, 3]. Having a family member translate during the session is often counterproductive to the therapeutic process.

Family

In the Arab culture, the family constitutes the core organizational structure of the individual and group identity [3]. Individuals are frequently referred to by an alternate name underlining their family affiliation. A designation such as *Ibn* (the son of …) preceding the name of the individual's father or family name is used. Another common designation is *Abu* (the father of…) followed by the name of the oldest son of the person. Due to this strong affiliation with family, Arab Americans may present initially as reserved when interacting with people outside of their networks and as a result building trust with them may take more time [41]. The Arab American individuals may be more invested in the family identity than their individual happiness and personal needs.

The extended family is also a larger social network that plays an important role in the Arab's everyday life. It is not unusual to see many generations of the same family living in the same residence or close to one another [12]. In the country of origin, extended family members help with housework, child care, and parenting [40]. This network is significant in major crises or events, helps the sick members of the family, and can provide emotional and economic support [18]. Arab American will always go to a family member when in need for emotional and financial support and even advice. They may show discomfort in discussing personal issues with a non-family member. This may be due to the potential threat such an act could pose to the person's sense of loyalty or the dishonor it may bring to his or her family [44]. Instead of seeking professional help, an Arab American may seek psychological comfort from a family member, typically of the same gender [2]. For the Arab patient, family members would typically assist throughout the help-seeking process and the choice of treatment approaches [11]. Family members may even interfere with the disclosure of medical information to the patient. This is especially true in the case of severe or terminal illnesses such as cancer. The family may ask the treating team not to inform the patient of their diagnosis for fear of the patient "losing hope." On the other hand, the patient may sometimes pretend ignorance of the severity of the illness to spare their family the distress and emotional pain.

It is important to note that the above family practices are less and less valued by younger generations of Arab Americans creating a significant intergenerational stress [3]. In contrast to their parents, younger Arab Americans may tend to distance themselves from their native culture. Urbanization has also had a major impact on the Arab family and their cultural idioms. For example, younger Arab Americans may be rushed for time, for money, and for delivering care to their children. They find themselves struggling between caring for their elder parents as their culture dictates while providing for their own children.

The level of involvement of Arab patients with their families may be a source of indecision and guilt for fear of disappointment of the family [29]. When working with an Arab American, the mental health provider should take into consideration that emphasizing individuation does not necessarily serve the treatment objectives [18]. An alternative would be to understand the individual within the group and allow for systems remediation.

Gender

Case Vignette 3

30-Year-Old Moroccan Woman With a History of Domestic Violence

Lamia is a 30-year-old Moroccan-American woman of Muslim faith. She spent the majority of her life living in Morocco before moving to the United States. As the oldest of four girls, she played a significant role in helping to raise her sisters from a very young age. She married a Moroccan man soon after finishing high school in an arranged marriage. Lamia had three children with her husband, a son and two daughters.

Two years ago, Lamia was referred to a mental health clinic after a significant history of domestic violence perpetrated by her Moroccan husband. She had filed for divorce, and a restraining order was already in place at the time of her referral.

Upon meeting with the mental health professional, Lamia expressed great fear of her husband, describing her struggle as "fighting an evil man." She reported severe bouts of depression stemming from years of trauma and discord within her family. She revealed a life that had been full of threats, violence, male privilege, and entitlement. She expressed much disappointment that her family no longer held respect for her despite all she had done to care for them. More than once, Lamia had to make the difficult choice to openly defy her family's wishes. Discussing the subject of divorce with her parents often resulted in insults and threats. She was denied attention and affection and was judged by her family to be a "loose" woman.

Throughout treatment, Lamia described conflict created by her fear of beginning a new relationship yet also not wanting to be alone. She disclosed feelings of loyalty to her ex-husband that continued even after the divorce had been finalized. Dating other men felt *haram*, or forbidden, similar to having an affair. Her husband continued to harass her with phone calls, often calling her a "whore." Lamia chose to share custody of her children with him as she felt it was important for them to grow up with a father.

In addition to traditional approaches often utilized in cases of domestic abuse, it was important for the therapeutic work with Lamia to also focus on understanding the more unique cultural aspects of her situation. Basic needs such as safety were addressed ensuring the effectiveness of her restraining order and pairing her with a social worker. Lamia's strengths were emphasized throughout treatment, as was her need to gain an understanding of her depression and fear generated from years of trauma. Lamia was empowered to test a new outlook on life and enter new relationships. The mental health provider remained sensitive to the importance Lamia placed on family, despite the rejection she had endured. Attempts were made to include her parents in the treatment. The mental health professional learned about the role of family and the dynamics of romantic relationships in Lamia's culture of origin. Lamia was encouraged to explore her identity as a Moroccan woman in America and educated about her rights as a free woman. Lamia's adjustment to American society was explored. Most importantly, she was helped in maintaining a balance between her individual goals and upholding her culture and Muslim faith. In her work with other Arab American women, the mental health professional avoided the generalization from Lamia's case and the common stereotype of Arab women being oppressed. (end of case vignette 3).

Among Arabic countries, gender roles differ widely. Women in Lebanon and the West Bank may be highly educated and secular, drive cars, conduct business, and wear Western dress. Women in the Gulf may practice few of those activities and may be completely covered by a *burka* or a *chador*. In either place, women are expected to get married, raise children, and to be attentive to the males. Arab societies are highly patriarchal. They remain as such even when members emigrate to United States. Male dominance remains strong and the man is identified as the main source of authority [11]. Women in these societies are expected to spend most of their time taking care of their families, and it is quite uncommon for them to have careers [60].

There is a tendency in the West to stereotype the Arab woman [24]. The general perception remains one of oppressed, abused, and having to abide by religious and social rules [18]. This misperception is especially true of Muslim Arab women and is often thought of as a reason behind an inhibition in Arab women's emotional, social, and sexual development [24]. Such stereotypes may likely be related to the fact that Arab women, while having a powerful presence in family decisions, tend to express it privately [3]. However, more recently, Arab women have been challenging these stereotypes, and rather, a trend toward portraying them differently and more accurately has been observed. The movie *Caramel* is an example of this trend. It portrays the struggle of Arab women, like Lamia in the case vignette, toward successful careers and independence as they age, engage in same-sex relationships, and deal with "the culture of virginity," within the confines of their culture (http://movies.nytimes.com/2008/02/01/movies/01cara.html?r=0).

The process of adjustment to American society presents significant mental health challenges to Arab women [61]. Much of the available literature on this subject has documented a higher risk to develop depression compared to males. This is likely caused by the expansion of the responsibilities attached to their main role of household management and child rearing leading to excess stress [24]. In a study examining female Jordanian immigrants, Hattar-Pollara and Meleis (1995) found that women experience significant sadness, anxiety, and social alienation in the face of the multiple acculturative stressors [20]. These stressors included societal bias, financial duress, management of the household, preserving the ethnic identity and the cultural heritage, and protecting their children from behaviors that they perceive unacceptable [20].

In the United States, many Arab women are seen attempting to cross a bridge socially and culturally [62]. They search for solutions that feel more acceptable to them in the context of their lives in the United States. While being careful not to violate their cultural value systems, they seek to break from traditional and patriarchal rules as the blended case demonstrates above.

Acculturation

Acculturation refers to the adaptation process to a new society or culture. In acculturation there is interplay between immigrant's attitudes toward the culture of origin and the host culture [63, 64]. Four possible forms of acculturation have been described: assimilation, integration, separation, and marginalization. Assimilation is the full immersion into mainstream majority culture. Assimilation may not necessarily mean well-being. It has potential positive or negative effects on the mental health of the immigrant [14]. Integration suggests a balance between one's heritage and the host culture. Separation is the preservation of one's cultural ties with no aspects of new host culture, while marginalization means no connection to either heritage or host country. The mere enumeration of these different forms of acculturation can point how problems in acculturation arise especially in traditional cultures like the Arab one. Despite having a common language, immigrants from the same area of the world may differ in their patterns of acculturation. This difference depends on the particular country and culture of origin [65]. The process, referred to as acculturation stress, can be accompanied by many challenges that are often hard to overcome [14]. The acculturation process is influenced by factors, including country of origin, the duration of presence in the United States, circumstances leading to emigration, the presence of family members remaining behind in the home country, access to home country, future intent to live in the United States, proficiency in English, and accent in spoken English [23] (Fig. 9.1).

Exploring the degree of acculturation should be an integral part of the mental health assessment of Arab Americans [66]. This plays a special importance in shaping the attitudes of Arab Americans toward seeking mental health services. Acculturation stress can potentially be expressed by a variety of psychological symptoms, such as feelings of marginalization, identity confusion, physical complaints, anxiety, depression, and suicidal ideation [67]. Learning a new language as well as new values and laws can exacerbate this stress. The same stress is present when they face discrimination and racism [68]. When Arabs emigrate to the United States, they are faced with a significant change in their socioeconomic status [24]. This is possibly related to their inability to afford education, poor compensation at work, and the difficulty they have in finding employment in the United States commensurate with their educational level [7].

The assessment of the degree of acculturation also encompasses the degree of identification with traditional values as compared to the adoption of Western values. Transgenerational differences between members of the same family or between different subgroups of immigrants can exist. Some Arab Americans may identify themselves as Caucasian and experience no link to their culture of origin which is more common if they are born in the United States [22]. Other Arab Americans would rather seek greater

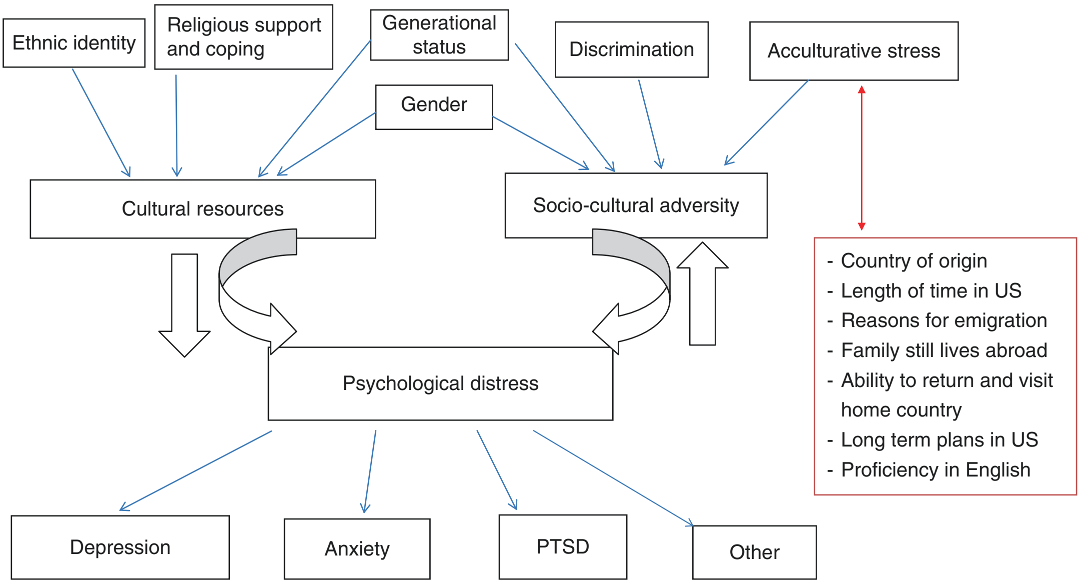

Fig. 9.1 Acculturation as a dynamic process

connection to the Arabic identity [22]. Intergenerational conflicts can arise between parents and their "Americanized" children, and parenting techniques previously used in the country of origin may no longer be applicable. Corporal punishment, common in certain traditional cultures, may be considered physical abuse in the United States. Physical violence or domestic issues may face legal consequences that the recently immigrating Arab may not know. The fear and guilt associated with losing one's native culture and the anxiety related to adjusting to the new culture can lead to significant stress and potential identity confusion. The lack of sense of community and absence of the extended family network only render this process of acculturation more stressful [24].

Discrimination

Discrimination is a significant stressor among resettling immigrants and a major factor negatively impacting their health status and mental health outcomes [3, 68]. Discrimination, which involves a cognitive appraisal of threat from others, can affect mental health negatively by impeding the social adaptation of immigrants [65]. This was hypothesized to be caused partly by the immigrant identifying more with their native group rather than with the host society [66].

Even after many years spent in the host country, the prevalence of psychiatric symptoms in the immigrant population continues to be elevated despite a documented decline over time [66]. Multiple studies involving adult refugees found discrimination to predict psychological distress and to be associated with depression and PTSD [66, 69]. Immigrants with higher perceived discrimination experience higher psychological distress and lower trust in the new society, which could result in a potential underuse of mental health services as a consequence [3].

After 9/11, discrimination, bias, and violence targeting Muslims and Arabs increased in the United States [3]. Since then, this population has faced increasing scrutiny that resulted in a higher incidence of mental health issues. Profiling of traveling passengers became ordre du jour often not helpful for the safety goals it was trying to achieve [35]. However, only minimal attention has been given to this issue by research studies [3, 70, 71], and the assessment of the impact of these events on this population remains poorly understood.

Perhaps in response to this lack of research, there has been a movement among Arab American women to fight against discrimination through political activism [72, 73]. Many have exercised such activism by wearing the *hijab* (veil covering the head and body) in public spaces where they have been criticized or by organizing events raising awareness and speaking out against abusive behaviors. Arab American women have also worked to actively challenge stereotypes often held by American compatriots as well as the rigidities within their own cultural and religious backgrounds [62]. In fact, a clinical study revealed that Arab American men and women may respond differently to discrimination, where men tend to develop more associated psychological symptoms [69].

Religious Considerations

In mental health, religious and spiritual practices often play a significant role in the treatment process for people with strong faith or who are highly spiritual. This is no exception for Arab Americans.

Historically, Islam has had a good relationship with medicine [1]. Many Muslims have strong beliefs about the role God plays in health, illness, and treatment [1]. The word *Islam* translates to "to submit," i.e., to submit to the Will of God. Highly religious Muslims may hold the belief that humans yield little power over health matters and decisions as God Almighty has ultimate control. When talking about their illness, they frequently use terms like *al-hamdu-lillah* ("praise to God") and *insha'Allah* ("by God's willing") [1]. Prayer holds a special place in the well-being of the individual. In addition, many regard envy or the evil eye, referred to as *hasad* in Arabic, as a main etiology of disease [1]. To a Muslim, the human body is considered a gift from God to be treated well [12]. The Islamic scriptures emphasize the importance of a healthy lifestyle, and Muslims are expected to acquire knowledge and to seek treatment for their physical and mental problems [1]. As such, medical advancement and physicians are highly valued in Islam [1].

While Islam does not mandate its followers to seek treatment from a Muslim provider, many Muslims often prefer that their provider be Muslim given their shared religious background [1]. Some Muslim patients will involve a religious figure or authority in their treatment [1]. Similar to other minority communities, clergy are frequently asked to perform not only their traditional religious and spiritual role but also a mental health provider's one [3]. In Islam, the *Imam*, a male clergy member who leads prayers and gives the sermon on Fridays, is sometimes resorted to for counseling services regarding social and family issues as well as mental healthcare [74]. They use the *Koran* (the Islamic holy book) and the *Hadith* (holy Scriptures of the prophet) as tools [74]. In one study, 74% of mosques in the United States were found to provide counseling to couples or families [74]. Despite being at the forefront of such services, *Imams* may feel that they lack the know-how and resources to address those issues adequately [74].

Among Arab Americans, several differences exist between Muslims and Christians with respect to mental health [14]. Muslims are more likely to maintain ethnic identification with Arab religious and family values and a higher religiosity than Christians [14]. Christians have been found to have less acculturative stress and an overall better adjustment within American society. This has been hypothesized to be due to maintaining lower ties with their country of origin and sharing similar religious affiliations with most Americans [14]. While both Muslims and Christians express the same desire for integration into the American society, Muslims feel more alienated and discriminated especially after 9/11 [14].

Clinical Recommendations for Working With Arab Americans

The higher rates of anxiety, depression, and PTSD in Arab immigrants in the United States and the effects of immigration on their health status would benefit from further study in order to validate the existing findings and develop evidence-based culturally sensitive clinical strategies for assessment and treatment [75]. In the clinical setting, certain cultural characteristics and culturally sensitive etiquettes could greatly facilitate the provision of mental health care by the providers working with an Arab American. The table below was created to summarize the work of many authors who have written on this subject [11, 24, 59, 76, 77]. It provides recommendations that could be used in the daily clinical setting but also could help any professional interested in this population (Table 9.2). While the clinical experience shows a great advantage for the professional to be of

Table 9.2 Clinical recommendations for working with Arab American patients

Clinical issues	Arab American characteristics	Recommendations
Patient-provider relationship	Emphasis on trust in rapport building	Do not assume resistance if patient doesn't readily open up
	Different notions of time	Give the patient time especially when discussing personal and emotional aspects
	Provider seen as an authority figure	Do not assume resistance if patient is late to the appointment
	Importance of social courtesies	Be aware of your own limitations in providing care
	Safety issues: suicidality, violent behavior, neglect	Study your views of Arab Americans and their effect on your work with this population
		Do ask about them but do not consider a negative answer as the definite one if everything else is pointing to the contrary. When in doubt, attend to safety issues urgently by consulting with a provider who is aware of the patient's cultural differences
	Termination of treatment	Professional appropriate dress
		Respect formalities (sole of shoes facing the patient is considered an insult)
		Always shake hands at the beginning and the end (except when opposite provider-patient gender, especially with pious Muslim female)
		Explain that termination is a growth/learning process. End with sentences that express "hope" rather than "abrupt stop"
		Offer the patient to communicate with provider (therapist) when needed in the future if any issue needs to be revisited or if patient is in acute distress
Language	Different meanings of Arabic terms	Be aware of cultural differences in word use
	Use of euphemisms	Avoid the use of jargon
	Repetition as a means to emphasize ideas	Expect patient to repeat or ask the same question for reassurance
		Use open-ended question
Attitude toward mental health	Unfamiliarity with mental health services	Orient to service provided and confidentiality and explain the role of the provider
	Fatalistic attitude	Assess patient's expectations of treatment
	Religious and traditional healers	Consult and collaborate with religious and traditional community figures
	Expectation of minimal participation in treatment	Use structured and didactic psychotherapies rather than existential techniques

Table 9.2 (continued)

Clinical issues	Arab American characteristics	Recommendations
Role of family	Family as the core social structure	Establish alliance with the family of the patient and engage important family figures in the treatment and invite them to sessions when appropriate, family therapy recommended
	Patriarchal structure	Discuss family expectations and their role in patient's presentation and treatment
	Family members involved in decision-making	Do not assume individuation from family as a goal of treatment or sign of improvement
	Nonverbal communication between family members	Avoid direct confrontation between family members during session
Gender	Stereotype of Arab women oppressed	Do not assume that all Arab women are oppressed within their culture
	Discomfort with professional of opposite gender	Do not assume that all Arab women are the same
		Gender matching in interpreters and healthcare professionals
Display of symptoms	Symptoms expressed somatically	Avoid pathologizing somatic symptoms
	Discomfort with discussion of illness	Assess cultural background and its relation to current presentation
		Consider the cultural context when assessing somatic symptoms
		Address uncomfortable subjects indirectly
Acculturation	Migratory experiences	Understand the immigration experience and its effects on ethnic identity and economical and psychological status
	Refugees/experienced trauma	Explore cumulative, family trauma as well as individual trauma
	Cultural identity	Allow time for trust and to open up about trauma
	Transgenerational differences	Explore ambivalence about ethnic identity
	Discrimination and stereotyping	Be aware that Arab Americans are not considered an ethnic minority in the United States
		Include categories like “Arab American,” “Arab,” and “Middle Eastern” on forms that require background information
		Study past and current political events in the United States and the Middle East, the patient's culture of origin, and their effects on the patient's current condition and functioning
		Explore the difference between various generations of Arab Americans
		Assess the level of potential discrimination experienced by the patient
		Explore effects of discrimination on self-image, ethnic identity, and social interactions
		Examine the impact of media messages and stereotypes on your beliefs

similar background, one needs be aware of one's own limitations in cultural sensitivity, specifically given the levels of diversity within the Arab community.

Most Arab clinicians practicing both within and outside the Arab world are aware of the enormous diversity that exists among the Arab populations. This diversity encompasses the many dimensions of culture including race, religious affiliations, cultural norms and values, language/dialects, social and political contexts, professional and educational levels, socioeconomic status, and acculturation levels. When working with an Arab American, clinicians of Arab origins fare better in their therapeutic plan when they adjust quickly and flexibly their perceptions and interventions during the therapy process. Such adjustment guides and helps the clinician calibrate how much of the work can be geared toward fostering individuation and/or how much of the work needs to remain within and meet a more traditional cultural stance.

The fatalistic attitude of some Arab Americans toward health issues and the unfamiliarity with mental health services can result in an initial level of resistance to treatment [53]. The health provider must be attentive to allot a longer time to the initial rapport building with the patient. For certain patients, building trust may even supersede the resolution of the problem [61]. Arabs are highly affiliative and cherish friendships and close personal connections much more than their commitment to tasks and deadlines. The provider should not assume this to be a form of resistance to treatment. The same caution should be exercised when terminating a therapeutic relationship. Termination should not be perceived as rejection or as an irreversible process. "See you some time again" may be more acceptable than "goodbye, good luck or farewell."

Verbal communication is a vital factor in the provision of care to Arab Americans. The Arab patient may use more repetitions, and his or her verbal expressions may be more intense. The provider is encouraged to use more open-ended questions and to be aware of the differences in the nuances of words between English and Arabic [61]. When discussing negative outcomes of an illness or a situation, the provider is advised to avoid referring directly to the patient and is rather to use the third person [53, 61]. Medical interpreters should be fluent in both languages and be knowledgeable of the cultural characteristics of this population [61]. Same gender interpreters are preferred [61]. In the absence of medical interpreters, the provider should avoid the use of family members for interpretation and rather attempt to find within the healthcare profession an unrelated individual of the same background or refer to an Arab-speaking provider when possible.

Nonverbal conventions also play a significant role in the clinical care of an Arab American. While the Arab patient attaches significant importance to social courtesies and hospitality, the notion of timeliness in the Arab culture differs significantly from that in Western culture. The word *boukra*, translated literally, means tomorrow. For the Arab, it may mean a "long time or sometime in the future." For example, the patient may be late for appointments or may cancel them without notification. These cultural nuances are important to grasp by the provider in order to contextually understand their patient's behaviors and not mistake them for disrespect or disinterest in treatment.

In addition, the notion of "personal space" is different for the Arab individual compared to the Westerner. The provider may see his patient stand or sit too close to his family members or close friends [53]. In contrast, the Arab American may sit too far from his or her provider especially if of the opposite gender or may avoid direct eye contact [61]. Arab women, especially Muslim, may feel uncomfortable being in a room by themselves with a male provider. Also, women who observe the *hijab* are more likely not to shake hands with the male provider [61]. Rather, placing his hand over his chest or heart would be an appropriate substitute for the male provider [1]. Gender matching between the Arabic patient, especially Muslim women, and healthcare provider and the interpreter could also be a crucial element in how much information is disclosed [1].

In psychotherapy, the Arab American individual tends to be less psychologically minded than the Western individual [50]. The Arab culture predominantly focuses on the “other” and hence may offer less potential for introspection or assessment of one’s own needs and experiences [29]. Short-term, didactic, and structured psychotherapeutic approaches may be more readily accepted by the Arab American as compared to insight-oriented modalities [15]. In other cases, the cumulative family or collective trauma and the associated high distress level and comorbid psychiatric illnesses may prevent the disclosure of prior experiences and symptoms. A higher level of trust and sometimes loosening therapeutic formalities could facilitate such disclosure. In these instances, a longer course of therapy would be the better option.

For Arab Americans, identity is derived from the family. The individual’s commitment to family responsibilities is highly praised and lived by values. For example, an individual is supposed to take care of sick family members and the elderly. By the same token, an Arab will turn to family members and closest relative when needing help. Family dynamics generally rest on a patriarchal system where the young respects the older. Furthermore, medical decisions are frequently taken by the family as a whole rather than by the patient. Given this strong presence of the family in the life of the Arab patient, the clinician may be faced with a potentially overbearing family. To best manage this cultural consideration, the health provider is encouraged to adopt a family systems perspective that respects family cohesion and takes into consideration the influence of key family members in the life of the patient [19]. The patient’s family goals and expectations should be evaluated and individuation from his or her family avoided [18]. The collaboration with family members, community leaders [19], interpreters, and other caregivers involved in the patient’s care is essential.

LGBTQ+ Arab Americans and Their Families

Case Vignette 4

A 21-Year-Old Syrian-American Woman With Anxiety

Aidah is a 21-year-old female born in Syria. She emigrated to the United States at age 6 along with her parents, an older brother, and two younger sisters. Aidah’s family is Muslim and resides in a New Jersey neighborhood with a sizeable Syrian population. Her father works as a physician. Her mother worked as an English language teacher in Syria before coming to the United States and now primarily attends to household responsibilities. Aidah’s parents are socially conservative and strive to maintain the Arab identity of their family. While her family arrived in the United States just 3 years after the 9/11 attacks, Aidah experienced little overt racial or religious discrimination throughout her childhood. Within the last 2 years, however, growing awareness of conflict in the Middle East and increased attention to immigration policy have given rise to at least three hate crimes aimed at Aidah’s family, including a racial slur written in graffiti on their garage door.

Aidah was homeschooled throughout most of grade school. She attended a private high school with a diverse population where she first gained exposure to more liberal, Westernized culture. Aidah now attends a prestigious university approximately 3 hours from home and is pursuing a degree in computer science engineering. Her parents highly value education for all of their children and expect Aidah to pursue a doctoral degree in her field. They also expect Aidah to soon get married and start a family.

Aidah presented to her university’s counseling center with concerns about increased anxiety, attention difficulties, and memory problems. During the intake session, she was quick to ensure that the content of her sessions could not be shared with her family or instructors and revealed that her family would likely not approve of her seeking treatment. The therapist, a White female, educated Aidah about the limits of confidentiality and reassured her that she could not share information with anyone without her written permission. Later in session, Aidah expressed feeling conflicted about her identity as an Arab woman in the United States. She described herself as having “two faces,” one that she shows with her family and a second that she shows with her peers. Aidah shared that she drinks alcohol and occasionally smokes marijuana with her friends. She noted that she does not wear *hijab* regularly and is beginning to question her faith in God. Aidah acknowledged feelings of guilt as well as continuous worry about what might happen if her parents were to learn about her behavior. Throughout the intake session, Aidah’s therapist was careful to assess Aidah’s acculturation level, immigration story, and level of identification with her Arab culture, in addition to typical psychiatric variables.

Early sessions with Aidah focused on rapport building and skill building interventions, such as relaxation and organizational techniques. Eventually, Aidah disclosed that she had been in a romantic relationship with a woman for approximately 8 months. She shared that her partner, a 24-year-old American woman of Indian descent, is dissatisfied with her refusal to tell her family about their relationship. The therapist attended to the possible consequences of revealing her relationship to her parents; Aidah confirmed that she would likely be viewed as morally or mentally ill and potentially ostracized from her family. She stated that her parents not only disapprove of same-sex relationships but that they would also reject her relationship based on the ethnic and religious identity of her partner. Aidah also acknowledged doubting the “authenticity” of her sexual identity at times and expressed wonder if peers in high school and now college had too easily influenced her.

To help Aidah address these concerns, the therapist provided emotional support with no judgment about whether Aidah should embrace her sexual identity. Instead, Aidah’s symptoms and concerns were normalized, and both the affirming and rejecting aspects of her Arab culture were acknowledged. For the time being, Aidah decided to keep her relationship private from her family. She processed current and potential losses with the therapist. Aidah was also linked with LGBT+ student organizations as well as LGBT-affirming Arab American groups on campus. (end of case vignette 4).

For nearly as long as mental health has been considered a distinct field of practice, the reigning view of homosexuality was pathological in nature. A momentous indication of change in this view occurred in 1973 when the American Psychiatric Association (APA) removed homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as a categorical disorder [78]. The idea that homosexuality occurred solely as a sign of “weakness” or severe psychological maladjustment was largely discredited by advances in scientific research. Alongside the movement toward more ethical responses to variances in sexual orientation has been the movement toward a more culturally sensitive provision of mental healthcare [79]. The rapid diversification of the United States has led to the creation and refinement of multicultural initiatives as well as an influx of research efforts designed to shed light on the provision of culturally sensitive mental healthcare [80].

In this way, it is crucial for mental health providers to understand that beliefs regarding homosexuality among Arab Americans may be as diverse as they are in the general American population. Level of education and acculturation may play a role in shaping one’s view of homosexuality. Arab American individuals with a high degree of acculturation – or, in other words, those that have adopted more Westernized values in lieu of traditional values – may be less likely to hold a pathologized view, for example. However, the overarching cultural message is that homosexuality is objectionable [81, 82], likely influenced by a myriad of complex factors, including the political, religious, economical, patriarchal, and even internationally influenced facets of Arab society.

Even in countries deemed relatively liberal in the Arab world, a discussion of LGBT rights has not openly permeated political agendas [83].

Same-sex sexual activity is often illegal, as is same-sex marriage and adoption. Same-sex relationships in most Arab countries are considered illegitimate in legal terms, and openly gay individuals are often prohibited from serving in the military [84]. By comparison, same-sex relationships may be grounds for time in prison, torture, castration, deportation, or death in more conservative Middle Eastern countries [84]. In these more conservative regions, anthropological research has detected a sense of insecurity that traditional morals will be diminished as the liberal practices of "the West" become more universally widespread. It has been suggested that these groups may perceive their own ideals of sexual expression as more acceptable, in terms of morality and general safety, to the less conservative practices of European and American cultures [83].

As a result, therapeutic interventions aimed at promoting acceptance of all sexual and gender identities by Arab American individuals or their families, even if applied skillfully, invite risk of particularly damaging familial and societal rejection and may actually promote further psychological conflict for all involved. There are a number of factors a mental health provider must consider – the Arab culture of the patient and their family, attention to intergenerational discord potentially created by an individual's upbringing within American society, the stance of one's professional organization (e.g., APA, ACA, NASW) on homosexuality as a non-pathological, normal variance in sexuality, the limited evidence that exists for the efficacy of conversion therapy and its potential for harm, and finally, the danger of placing an Arab American individual at odds with their family and culture. Keeping in mind the level of familial emphasis within Arab culture, this last variable is especially critical.

Most professional organizations within the mental health field, including the American Psychiatric Association [85] and the American Psychological Association [86], expect their members to abide by a written code of ethical principles and standards that encourage awareness and management of potential factors that may lead to harm in treatment and research. Individuals served deserve protection from harm by culturally insensitive care or abrupt, discriminatory referrals. Clinicians must be careful to choose interventions that do not pose a disproportional risk of harm (such as some conversion therapies, which seek to change a person's sexual orientation) or encourage confrontation with family or cultural values that could intensify problems with rejection or isolation. The APA discusses the need for affirmative responses that contest the criminalization, discrimination, and prejudice against homosexuality promoted by sexual stigma inherent in society [87], yet Arab Americans are often vulnerable in that they can face backlash from their communities if they become more open or accepting of homosexuality.

These subtle conflicts between professional standards and culturally sensitive practice can become more apparent when making treatment decisions. For example, in cases where a referral is contemplated, a mental health provider may consider their own competence and experience in working with Arab American clients. At the same time, the provider must gauge the potential harm a referral might bring to a patient and their family. Arab Americans underutilize mental health services as compared to other groups [11], and an indiscriminate decision to refer seriously undermines the amount of strength it may have taken to overcome reluctance to seek help in an unfamiliar culture.

In order to remain compliant with professional standards of practice, mental health providers should adopt a non-pathological view of homosexuality [87]. This means that they may be in direct disagreement with the Arab American family or individual to whom they provide treatment. Although few empirical studies have been done to address the specific mental health needs of Arab Americans, a set of clinical recommendations (see Table 9.2) have been developed to assist mental health professionals working with this population. Level of acculturation may serve as an important backdrop to conceptualizing the psychological concerns of an Arab American individual or family and shed light on the view of sexual identity or gender expression, as well as its etiologies. Mental health professionals are urged to consider past and current political events occurring both in the United States and the Middle East and to acknowledge the impact of media messages and stereotypes as well as possible discrimination individuals may have faced based on their Arab identity alone. Exploration of immigration experiences and its multilayered effects is crucial as there is potential for complex trauma, such as in the case of families who have left their countries due to war and political unrest. The dynamics of acculturation highlights a vital need to understand that an Arab American's concerns related to sexual or gender identity are not likely to occur within a perfectly sealed vacuum. Rather, they are heavily influenced and perhaps compounded by a multitude of variables.

Again, the role of family is central in Arab cultures, and an individual may seek to preserve their family identity before attending to their own needs. The families of Arab Americans may expect direct involvement in decision-making related to treatment goals and outcomes. As a result, it is important to establish a strong alliance with family members and hold family-oriented sessions, which should involve exploration of family expectations and psychoeducation regarding their role in the patient's psychological presentation and treatment. Therapeutic interventions that utilize direct confrontation should be avoided or used with caution, and a more indirect approach to sensitive areas of discussion is preferred. This knowledge is imperative where Arab American families request treatment for a family member's sexuality and openly object to their gender or sexual identity; this is a case in which a clinician might normally respond by promoting direct exploration of such a conflict.

In 2009, the American Psychological Association [87] proposed a framework of Affirmative Therapeutic Interventions for individuals who may seek treatment to change or "fix" their sexual orientation or gender expression. The first element of this framework is to take a client-centered approach based on acceptance and support. The removal of preconditions placed on the outcome of treatment is especially crucial when working with Arab Americans and their families – a "push" for a particular outcome, especially one that may contradict the family's feelings about sexuality, has the potential to create significant personal and family conflict. Although a clinician may understand that a reversal of sexual orientation is unlikely to occur, they must remain empathetic to the individual's desire to change or reject an identity.

This framework also stresses the importance of thorough and comprehensive assessment strategies. It must be understood that an individual's distress is complex and is not always directly tied to their concerns about their sexual identity, mirroring recommendations for general treatment that mental health professionals must take care to gain a full understanding of an Arab American individual, including their particular country of origin, culture, religion, level of acculturation, experiences with discrimination, and immigration and trauma history.

Assisting a client with active coping is a third element of this framework [87]. Cognitive strategies, such as tapping into cognitive distortions (i.e., all or nothing thinking, either-or dichotomies) and refocusing on the more accepting elements of one's religion and culture, are thought to be helpful in addressing a client's difficulty living within a society or cultural group that may not affirm their sexual identity. These strategies can be paired with a detection of negative self-appraisals and exploration of internalized stigma. This affirmative framework also encourages mental health providers to consider emotion-focused strategies to improve a patient's ability to cope with loss and grief, especially for those individuals who have lost or had to give up membership in a particular group (i.e., their religious group). Such strategies should also address uncomfortable feelings of dissonance, ambiguity, and uncertainty surrounding sexual experiences and identities. These coping strategies are highly relevant for Arab Americans with families or communities who hold a negative view of homosexuality. Research has found mutual support groups to be helpful for individuals struggling with their sexual identities [88]. As a result, providers should emphasize social support and include both "ex-gay" and LGBT-affirming groups as well as individuals trusted by the patient who have been consistently supportive. It is recognized that gaining social support can be especially difficult for individual's whose communities "reject" their sexual orientation; in such cases, a provider may reframe this problem as an external rather than internal issue [86]. Because of the special emphasis on the importance of family within Arab American cultures, the efficacy of this element can be unclear.

Finally, mental health providers are encouraged to engage in identity exploration with their patients and to maintain an understanding of identity development [87]. Mental health providers should possess knowledge of models of sexual minority identity development as they participate in the active process of "exploring and assessing one's identity and establishing a commitment to an integrated identity" [86]. This approach holds no assumptions, however, about a desired outcome and recognizes that outcomes may vary and change with time. For example, an individual may either adopt or reject their sexual identity or choose not to specify a sexual identity at all. In addition, this approach seeks to expand previously rigid or inflexible definitions of various identities. A provider must explore the multiple identities that exist within a single person. A gay Arab American, for instance, may be having difficulty integrating their American and Arab cultural identities, on top of a struggle between their religious and sexual identities. Arab Americans are also more likely to hold identities strongly tied to their collective social groups with less emphasis on an individualistic perspective of the self.

Conclusion

Arab Americans represent a highly diverse community that remains poorly understood despite the significant media and public attention it has received in the recent years. The diversity of Arab societies is often missed in clinical assessments and treatments. This level of diversity creates challenges even to the Arab clinician treating an Arab patient. Cultural sensitivity cannot be assumed in the culturally similar patient-provider dyad. The paucity of evidence-based knowledge of Arab American mental health correlates impedes the professional's ability to provide culturally sensitive treatments.

This population continues to diversify and evolve even further with the generations of offspring of Arab American couples and the current and future waves of immigration from the Arab world. In order to understand the evolving clinical and cultural characteristics and to meet the medical and mental health needs of this population, significant resources are necessary. The researchers, educators, and professionals working with this community need culturally sensitive guidelines and data to support their endeavor. This is especially crucial in mental health where missing cultural considerations and nuances can lead to misdiagnosis and suboptimal treatments. Training professionals in culturally sensitivity avoids the unintentional violation of traditions and beliefs and counters stereotype and misconception [61]. The training of bilingual professionals and medical interpreters who understand not only Arab Americans but also the dual cultural heritage of their American-born children will be critical in building culturally sensitive health services. This is especially important in women's issues and women's rights whether it is about acculturation, gender roles, and new family laws or in the prevention of domestic violence. As Arab American women adjust to living in the United States, they face the challenge of preserving their Arab cultural values while heading toward liberation. The liberation of women is not simultaneous with the abandonment of important and valuable customs.

Further research should be conducted to study the cultural variations between the diverse groups of Arab Americans and their mental health with a special emphasis on family and gender issues. It should study the differences between the various ethnic and cultural groups among the diverse Arab American populations and gain a better knowledge of their attitudes toward mental health

[18]. Future research should identify the prevalence and risk factors of mental health disorders in this population and support the development of validated strategies of assessment and culturally sensitive modalities of treatment [18, 25]. Studies should use systematic hypothesis testing methods and larger and more diverse population samples [6]. More effort should be geared toward developing culturally sensitive and validated mental health research tools and scales in this population. Risk factors such as acculturation and other psychosocial predictors of psychiatric distress and coping mechanisms should be explored extensively [7]. Finally, a better understanding of the medical and mental health of this population would better guide the creation of effective strategies for healthcare delivery in this growing community [18, 25] and mitigate against unsafe practices both by providers and patients.

As this community diversifies further and undergoes the process of acculturation, the mental health characteristics and needs of the Arab American population will continue to evolve. The scope and momentum of current research, education, and service delivery, as well as emphasis on intersectionality, should parallel this evolution.

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10

An Approach to Mental Health in Asian Americans

Shirin N. Ali

Introduction

This chapter will describe an approach to mental health assessment and treatment in Asian Americans, a diverse and rapidly growing group within the US population. The chapter places an emphasis on understanding concepts related to how Asian Americans may understand mental health conditions and how mental health professionals can approach this population in a culturally sensitive and curious manner. I hope this chapter will help mental health clinicians, educators, and researchers develop a thoughtful and flexible approach to evaluating and working with Asian American patients. To develop a complete understanding of the patient, the mental health professional will have to weave together the patient's unique health beliefs, culture, language, family, religion, narrative, genetics, pharmacological history, and relevant life experience. Asian Americans cannot be treated as a monolithic group, and in the following pages, topics and themes will be raised that lead the professional away from viewing the patient's difficulties through only one lens and toward understanding the patient's unique subjective experience. After reading this chapter, the reader will hopefully gain more knowledge about Asian American health beliefs and culture and integrate this into his or her approach to mental health practice, education, and research to effectively help Asian American patients. This chapter concludes with three blended cases based upon my work and cases of colleagues shared with me from years of experience in working with Asian Americans. These cases will help the reader to synthesize the different topics and themes discussed in the chapter in realistic clinical scenarios. These cases will clearly demonstrate the complexity and diversity of Asian American patients and help to model an integrated approach to working with Asian Americans in a culturally sensitive manner in clinical, research, and educational settings.

Who Are Asian Americans?

Based on US Census information from 2016, there were an estimated 21.4 million persons of Asian descent living in the United States [1]. Asian Americans were the fastest growing racial group with the largest proportional population increase between the 2000 and 2015 census [2]. California and New York have the largest populations of Asian Americans at 6.5 and 1.8 million

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people, respectively [3]. It is an extremely heterogeneous group with tremendous diversity. Currently among people who identify with one country of origin, the largest subgroup among Asian Americans are of Chinese descent, followed by Indian Americans, Filipino Americans, Vietnamese Americans, Korean Americans, and then by Japanese Americans [2]. Not surprisingly, after English and Spanish, Chinese is the third most widely spoken language in homes in the United States. While Asian Americans have made tremendous strides in acculturation since the first Chinese and Japanese immigrants came to the United States in the mid-1800s, Asian Americans are still largely a population made up of immigrants, with 73% of Asian American adults having been born in another country [2].

Among Asian Americans, 26% live in a multigenerational family, defined by having at least two adult generations in the same household, which is higher than Whites, Blacks, and Hispanic Americans [2]. On the whole, Asian Americans have a relatively high educational status, as 51% of Asian American adults over age 25 are college graduates, compared to 30% of the general population. However, there is disparity of percentage of college graduates among different ethnic groups among Asian Americans. For example, only 18% of Cambodian Americans over age 25 are college graduates, which is lower than the general population. Approximately half of Korean, Chinese, Japanese, and Filipino Americans over age 25 are college graduates. Indian Americans have a much higher percentage of college graduates over age 25, 72%. These interethnic differences may reflect different immigration patterns from the countries of origin. While the median income of an Asian American household is $73,060, and higher than the national median, 8.5% of Asian Americans lived in poverty in 2009 [1]. Additionally, Asian American households are often larger than those of other ethnic groups. Asians make up approximately 11% of undocumented immigrants to the United States [2]. While these facts and figures do not reflect the diversity of the Asian American population, they help to provide a broad overview of the makeup of this group.

A Brief Immigration History

The first Asian immigrants to the United States arrived from Japan in 1843 and were soon followed by Chinese men who came in the 1850s and 1860s to work on the transcontinental railroad, on gold mines, and in agriculture [1, 4]. The Chinese Exclusion Act of 1882, which put an end to all new immigration from China, was a reflection of the opposition to Asians immigrating to the United States and becoming permanent residents. The Asian exclusion Act of 1924 was a continued response to concerns about Asian immigration, which limited the new immigrants per year from East Asia, Southeast Asia, and South Asia [2]. Asian immigrants were thought to be unable to assimilate into the United States population due to phenotypic differences in appearance, unlike European immigrants. A Supreme Court case in 1923 of the *United States* vs. *Bhagat Singh Thind* denied an Indian immigrant the ability to apply for citizenship citing this concern in the official decision [4]. The doubt about the allegiance of those of Asian origin to the United States lasted well into the middle of the twentieth century. During World War II, over 80,000 US-born citizens of Japanese origin were held in internment camps by the government [4].

Immigration from Asia radically changed over the course of the twentieth century with different ethnic subgroups greatly increasing as a response to the loosening of governmental restrictions and quotas. For example, in the middle of the century, naturalization and immigration of the war brides of US soldiers from Japan, Korea, and Vietnam became permissible [4–6]. In 1965, the Immigration and Nationality Act ended quotas with regard to Asian immigration and lead to huge increases in the numbers of immigrants from Asia. This act also changed the ethnic landscape of Asian immigrants, who until that time had largely been from Japan, China, and the Philippines. In the 1970s, there was an influx of refugees from war-torn Laos and Cambodia [7]. Currently, Asians among immigrants are most likely to come to the United States with work visas but also come through student visas, temporary visas, and unauthorized status [2].

Today, as a result of the varied historical waves of immigration, there is tremendous diversity among the immigration and acculturation experiences in Asian Americans. The term Asian American captures the breadth of experience of an elderly Japanese American man whose family has been in the United States for many generations and the 18-year-old female refugee from Myanmar who recently arrived to the United States. Despite their age gap, the Japanese American man whose grandparents immigrated in one of the early waves immigration will likely be more acculturated than the 18-year-old who arrives to resettle in a very foreign culture. As the chapter's focus turns toward mental health in Asian Americans, it will be important to continue to consider each patient or family's immigration history as it informs aspects of who they are and what issues may arise when they may present themselves to mental health professionals.

Prevalence of Mental Health Disorders in Asian Americans and Utilization of Mental Health Services

According to the groundbreaking Surgeon General's Report on Mental Health in 2001, there was little adequate data about the prevalence of mental health disorders in Asian Americans. One of the larger studies mentioned in this report, the CAPES study, demonstrated that Chinese Americans in the Los Angeles area had a moderate rate of depression, with 7% of study participants endorsing having experienced depression in their lifetime and 3% in the prior year [8]. Studies in the 1980s and early 1990s that assessed symptoms of depression rather than the diagnosis of depression in Asian American populations found higher rates of depressive symptoms in Japanese Americans, Korean Americans, Filipino Americans, and Chinese Americans in various major cities in the United States [8]. One of the concerns underscored in the Surgeon General's Report is the lack of adequate data about DSM diagnoses in Asian Americans, and the report questioned whether or not Asian Americans truly have lower rates of psychiatric disorders compared to other populations. Due to potential cultural bias in the reporting of and asking about symptoms, it was unclear whether or not accurate data about mental health conditions in Asian American was captured by numerous studies. Culturally informed ways of expressing symptoms, prevalence of somatization, and culture-bound syndromes were all raised as possible confounding factors. The report clearly states that there were inadequate data about the prevalence of disorders in Asian Americans who did not report mental health concerns and did not see mental health professionals. Rather than demonstrating that Asian Americans were a resilient "model minority" group, the report showed that the scope of mental health problems of Asian Americans was not adequately detected. Without perceiving a realistic mental health need, treatment could not occur, except for high acuity populations, like Southeast Asian refugees with post-traumatic stress disorder, whose need was more evident [8]. A 2016 study by Cook and coauthors evaluated disparities in access to mental health care among different ethnic groups. Unfortunately, their study revealed that there has not been significant improvement in access to mental health care for Asian Americans from 2004 to 2012; persistently low access of rates to care continues despite the grave concern about this issue expressed in the Surgeon General's Report in 2001 [9].

Large-scale studies have yielded useful data about the prevalence of mental health diagnoses in Asian Americans and utilization of mental health services. However, diagnosis-specific studies have focused only on ethnic subgroups of Asian Americans, and there are no reliable data on the prevalence of psychiatric diagnoses in Asian Americans as a whole. One of the large-scale studies is the National Latino and Asian American Study (NLAAS) that reflects the prevalence of psychiatric diagnoses to be 0.8%. This study was designed to assess the 12-month prevalence of mental health disorders from 2002 to 2003 among Asian Americans and Latinos, to assess the psychosocial context of the emergence of the disorders, and to determine how often mental health services were sought, in comparison with White, Hispanic, and Black populations [10]. In one analysis by Dr. Jennifer Abe-Kim of the NLAAS data, 8.6% of the population surveyed sought mental health treatment compared to 17.9% of the general population when assessed in other large-scale studies [11]. In the general population, 41.1% of persons with a probable DSM IV diagnosis sought psychiatric treatment compared to 34.1% of Asian Americans. Additionally, the propensity to use mental health services was inversely correlated to generation of immigration. Second-generation immigrants were more likely to use mental health services than immigrants; third-generation immigrants were more likely to use mental health services than second-generation immigrants at a rate more similar to the general population [11].

In the NLAAS study, the prevalence of lifetime suicidal ideation in Asian American populations was found to be 8.8%, and the prevalence of suicide attempts was found to be 2.5%. Factors that were positively correlated with suicidal ideation and attempts include being female, conflict with family, a history of depression or anxiety, and perception of discrimination. Stronger identification and sense of belonging with one's ethnic group were negatively correlated with suicidal ideation and attempts [12]. The 2010 National Drug Use Survey on Health by SAMHSA, a large-scale survey on mental health and alcohol, tobacco, and drug use patterns among over 60,000 responders over 12 years old, showed that the rate of illicit drug use was 3.5% in the month prior, lower than Whites, Native Americans, Blacks, or Hispanics. Among the 38.4% of Asian Americans who endorsed alcohol use in the month prior, 8.8% were binge drinkers and 2.4% were heavy drinkers of alcohol [13]. Rates of substance abuse or dependence were lower among Asian Americans at 4.1% compared to other ethnic groups, which is consistent with what other studies have found [13] (Table 10.1).

Smaller-scale studies in specific ethnic populations of Asian Americans have identified prevalence rates in these subgroups, but conclusions from these studies do not necessarily generalize to the heterogeneous group of Asian Americans. For example, Yeung et al. in 2004 found the prevalence of major depressive disorder among Chinese Americans in a primary care setting in Boston to be 19.6%, much higher than the estimate from the CAPES study in Los Angeles described earlier [14]. Another study from 2000 found that the prevalence of panic disorder in Cambodian refugees being treated at a psychiatric clinic was approximately 60% [15]. Another study examined the prevalence of eating disorders in Asian Americans based on data from NLAAS study and found overall low prevalence of eating disorders in Asian Americans, less than 1% for anorexia and bulimia. Women had a higher lifetime prevalence of binge eating disorder than men, 2.67% compared to 1.35% [16].

Table 10.1 Findings from large-scale studies of mental health in Asian Americans

Study	Mission	Major findings
National Latino and Asian American Study (NLAAS)	Assess the prevalence of mental health diagnoses in Latinos and Asian Americans from 2002 to 2003	0.8% prevalence of mental h health diagnosis 8.6% of Asian Americans sought treatment compared to 17.9% of general population More recent immigrants less likely to use mental health services 8.8% lifetime prevalence of suicidal ideation
2010 National Drug Use Survey on Health	Assess tobacco, drug, and alcohol use in adolescents and adults	Rate of illicit drug use 3.5% per month, lower than other ethnic groups Among alcohol users, 8.8% reported binge drinking in the last month Rates of substance abuse or dependence, 4.1%, lower than other ethnic groups

Sources: References [10–13]

The author believes that it is difficult to draw conclusions about a particular individual based on these heterogeneous data. One interpretation of these data is that mental health professionals should expect that refugees from Asia will likely exhibit symptoms of anxiety disorders. However, with less high-acuity populations, the mental health professional should be more vigilant for mental health symptoms, which may be underreported or may manifest in different ways, as will be reviewed later on in this chapter.

The Surgeon General's Report in 2001, in addition to emphasizing the need for better epidemiological data on mental health conditions, also highlighted the low utilization of mental health services by Asian Americans compared to other minority groups, which has continued to be true in the ensuing decade when compared to Whites, Blacks, and Hispanics [8, 17]. Since that time, many studies have examined this question with differing results. Barriers for the individual Asian American patient may include any of the following: cultural bias in how the patient describes his symptoms, bias in how the clinician or researcher assesses the symptoms, decreased perception of need for treatment, stigma, foreign-born status, wishing to save face, initial use of family support and traditional healing methods, focus on somatic symptoms, length of time in the United States, lack of culturally appropriate services, lack of language appropriate services, and lack of health insurance [8, 11, 17–19]. For every 100,000 Asian American and Pacific Islanders, there are 70 Asian American and Pacific Islander mental health-care providers, which is less than half of the number of providers for Whites. Also, Asian Americans may have difficulty accessing the US health-care system in general, as suggested by the fact that Asian Americans who are Medicaid eligible are much less likely to have Medicaid than their White counterparts [18]. While it is not possible to review all of the nuances of the methodological difficulties in assessing the prevalence of mental health disorders in Asian Americans and the disparity in their treatment, excellent reviews are provided elsewhere [17, 18].

Idioms of Distress Among Asian Americans

It has been well established that certain ethnic groups, like Asian Americans, are more likely to express social or emotional distress through bodily symptoms and medical help-seeking, particularly in cultures where the expression of emotional distress may be discouraged [20]. Somatization has referred to physical symptoms in psychiatric disorders as well as physical symptoms without an organic cause. Historically, researchers have also noted a higher prevalence of somatization in populations who are making either cultural or geographic transitions, particularly refugee populations [20]. Asian Americans are likely to somatize as a result of tacit cultural prohibitions against verbalizing psychological distress. Somatization also may result in more help for the patient from religious figures, family, and traditional healers than expressing distress in psychological terms [21]. In a Japanese psychosomatic clinic, Nakao et al. found amplification of somatosensory symptoms occurred in patients who had difficulty identifying and expressing their feelings [21]. Another study found that among Chinese Americans, individuals who somatized were most likely to seek professional help and that individuals with anxiety or depression were less likely to seek help than those with somatoform disorders [22]. An earlier study of somatizers among Chinese American and White patients in Boston who did not express psychological distress found that Chinese Americans were more likely than Whites to be "true somatizers" and in both populations, somatization was associated with the presence of a mood disorder or an anxiety disorder [23].

More recent studies have questioned the assumption about the relationship of somatization and perceived need of mental health treatment in Asian Americans. Based on data analyzed from the NLAAS study, physical symptoms in Asian Americans were associated with a greater sense of need for mental health treatment [24]. In another study by the same authors, also based on data from NLAAS study, Asians were actually less likely to report three or more physical symptoms than Whites and Latinos [25]. Somewhat surprisingly, more acculturated individuals were likely to report more physical symptoms than less acculturated people, even with adjustments for psychological distress, medical conditions, and disability, which may reflect in part the better health of recent immigrants. Taken together, these findings suggest that somatization, while an expression of distress, can lead to greater perceived need for mental health services in Asian Americans. However, somatization alone cannot account for the lower utilization of mental health services by Asian Americans [24, 25]. It is also very important to be aware of the possibility of somatization in the primary care setting. While some Asian Americans with somatization may seek mental health care, others may seek help in the primary care or medical specialty setting. Practitioners in these areas should consider the possibility of somatization as well as mental health diagnoses when evaluating a patient' physical symptoms. The meaning and social use of somatization may also have shifted over time as the population of Asian Americans has continued to diversify in ethnic origin and acculturative status.

Cultural Concepts and Idioms of Distress

Cultural syndromes of distress are repeated clusters of symptoms and behaviors more prevalent to a geographic region, community, or group which can cause both physical and mental distress in an individual and may result in impairment of functioning and help-seeking behavior (DSM5). The symptoms may include somatic symptoms as well as symptoms that may or may not overlap with a psychiatric disorder classified in the DSM [26]. Specific cultural concepts of distress have been associated with particular Asian and Asian American populations and are a continued area of study. Psychiatric researchers and clinicians alike continue to determine how best to approach their diagnosis and treatment (Table 10.2).

Table 10.2 Common cultural syndromes of distress in Asian American populations

Name	Asian country where seen	Features
Amok	Southeast Asia	Violent and aggressive episodic behavior without clear cause, mostly in males
Dhat	South Asia	Anxiety about discolored or lost semen
Hwa-byung	Korea	Related to suppression of anger; insomnia, fatigue, panic, pain, GI distress, fear of death
Koro	Southeast Asia, South Asia, China	Sudden fear of genital retraction into the body and death from anxiety or paranoia
Latah	Southeast Asia, particularly Malaysia, Thailand, Japan, and the Philippines	Extreme sensitivity to fright with dissociative or trance-like behavior
Qi-gong-induced psychosis	China	Episodic psychotic or dissociative reaction after improper practice of Qi-gong
Neurasthenia	China	Physical and mental fatigue and dizziness, headaches, sleep problems, problems with memory, GI distress
Taijin kyofusho	Japan, Korea	Intense fear that one's physical features, smell, or behavior is displeasing or offensive to others

Sources: References [26–33]

Identification and management of cultural syndromes is a continued controversial area of inquiry, and the idea of a cultural syndrome has continued to be refined and reconceptualized. For example, a review on amok challenged the notion of this being only a culture-bound syndrome given the more frequent episodes of violence and aggressive behavior in Western countries as well as Asian countries, by people of Asian descent and non-Asian descent [27]. The author of the review recommended screening for amok in all patients in order to have amok as part of a differential diagnosis and expanding the assessment of a patient's risk for violence. The author of the review suggested treating people at risk for amok as psychiatrists would any patient at risk for violence, assessing for mood, psychosis, substance abuse, and personality disorders and recommending treatment to minimize harm for the individual and society in a person at risk [27]. Choy et al. examined two features of the offensive subtype of taijin kyofusho in patients diagnosed with social anxiety disorder in the United States and Korea and found an association between the culture-specific symptoms and severity of social anxiety, suggesting more overlap in DSM diagnoses and taijin kyofusho than previously thought. This conclusion raises the possibility of incorporation of other symptoms thought to be cultural into DSM criteria for psychiatric disorders, which has occurred with DSM5 [26]. The expansion of the notion cultural syndromes has also been raised by other studies that show that dhat or semen loss anxiety occurs also in China and Western Europe and that latah may occur in White and Black populations [28, 31]. The prevalence of culture-bound syndromes may also continue to shift. In their study, reviewing the history and prevalence of neurasthenia in China, Lee and Kleinman postulate that the worldwide impact of the DSM has made it less likely that Chinese psychiatrists use the diagnosis of neurasthenia in China [31]. Cultural syndromes and idioms of distress continue to evolve over time, particularly as technology and communication continue to impact the global exchange of information and ways of understanding illness.

There are methodological barriers to further characterizing cultural syndromes. One study described the development of a validated scale to assess symptoms of Hwa Byung in Korean college students but raised the question of whether or not the scale would necessarily be valid in Korean Americans [29]. Additionally, as with depression and other disorders in the DSM, clinicians and researchers are continuing to work to better refine the criteria of cultural syndromes. For example, the definition of taijin kyofusho in DSM5 compares and contrasts the disorder with the definition of social anxiety disorder, body dysmorphic disorder, and delusional disorder in DSM5. The DSM5 also notes that that clusters of similar symptoms of the disorder have been present in other contexts, such as the United States, Australia, and New Zealand [26]. Efforts are also being made to recognize new cultural syndromes, such as hikikomori, a syndrome of social withdrawal in Japanese adolescents and young adults who may avoid school or work for years and do not meet criteria for another psychiatric disorder [34]. Cultural syndromes and idioms of distress will continue to be a challenging area for clinicians treating Asian Americans as there is a strong need for additional research and consensus on how these disorders are conceptualized and managed, which has continued to evolve with DSM5.

Religion, Philosophy, and Health Beliefs

Many values and beliefs common among Asian American populations have underpinnings in Asian religions and philosophy. These value systems are comprehensive, describing the integration of the body and the mind as well and an approach to managing both one's internal and external world. Asian Americans are an extremely diverse group, and while all Asian Americans will not uphold these beliefs, it is useful to briefly review them here as they inform the conceptualization of mental health and illness as well as general cultural values in many Asian cultures.

Much of Eastern philosophy is based on principles in Confucianism, Taoism, Hinduism, and Buddhism. Confucian thought brought order to Chinese civilization by emphasizing concepts such as interpersonal harmony, acceptance of a person's place in society, hierarchy within the family with older adults and males in higher positions, unconditional obligation toward the family, and orientation toward the group rather than the individual [35, 36]. Taoism emphasizes the importance of maintaining balance and harmony both internally and with the larger world, respecting nature, and maintaining personal qualities of humility and receptivity [36, 37].

In Buddhism, the individual cultivates compassion for the suffering in others, acceptance of one's fate or karma as a result of acts in a past life, and an acceptance of the ephemeral nature of life, as well as emphasis on nonattachment to aspects of the self [38, 39]. Elements of animism, belief in the existence of spirits, gods, and ghosts and the belief in a larger spirit world infused in natural inanimate and animate objects, has informed elements of Asian philosophy from Taoism, Confucianism, and Buddhism that include respect or worship for ancestors as a virtue [39]. Hinduism and Islam are the most common religions in South Asian nations. Aspects of Hindu belief have overlap with Buddhism such as the values of knowledge of life, emotional regulation, control over desire, the value of humility, and the importance of societal duty [40]. Muslims also have a strong belief in destiny or fate, similar to karma, in that events occur because of the will of God, and similar ideas of sin to Judeo Christian religions. Many Muslims also believe in the spirit world of the jinn and some may have supernatural beliefs about the evil eye [41].

These different religions and philosophies are very tied to beliefs about health and the mind and body in Asian cultures, and patients use their beliefs as a way to understand their difficulties. What Western-trained psychiatrists may consider a psychiatric problem, an Asian American individual may conceptualize as a psychiatric problem, culture-bound syndrome, physical problem, spiritual problem, or some combination of all of these. For example, a Hindu Indian American man experiencing dhat may believe his symptoms of semen loss and physical and mental weakness are the result of excessive attachment to sexual desire and decide to pursue yoga therapy to help him detach from his sexual desire and restrict masturbation. He may have pursued traditional treatments after a dissatisfying experience with a psychiatrist who recommended that the patient start an antidepressant to reduce the patient's excessive worry about semen and reassured him that semen loss was not dangerous [42]. A patient may also ascribe to a more pluralistic health belief system and pursue allopathic and traditional treatments simultaneously. For example, a Chinese American patient may believe that his low energy and mood are the result of an imbalance of yin and yang and may wish to take traditional herbs from a root doctor along with the antidepressant recommended by his psychiatrist [42]. Understanding traditional beliefs may also help mental health clinicians, researchers, and educators gain insight into a family's approach to managing a particular condition in a family member and the challenges that may arise. When a social worker recommends that an elderly Vietnamese woman with dementia go to a nursing home to alleviate stress in the family, her primary caregiver daughter may acknowledge the difficulties of care giving but believe that it is her duty to care for her mother, that it may give her good karma, and that it is necessary for her to demonstrate compassion to those who are suffering. The breadth of religions and philosophies upheld by Asian Americans was briefly reviewed here, but the mental health clinician can improve their understanding of the individual Asian American patient's approach to his mental health by learning more about his or her particular belief systems.

Asian American Family Culture

Based on the deeply ingrained idea of filial piety in the vast majority of Asian cultures, the family is the unit on which society is based. Filial piety is a core value based on Confucian principles. It emphasizes the importance of family throughout the life cycle of the individual. Children are expected to demonstrate respect, support and sacrifice for their parents and ancestors, to care for their parents and as they age, and behave in a way that brings honor to the family name. While Western cultures are more individualistic and autonomy oriented, Asian cultures are more group oriented [35]. Some families may be hierarchical with the elderly and males holding positions imbued with greater authority or respect, though mothers may be more responsible for the emotional harmony of the family and have more covert influence [35]. Asian Americans are more likely to live in multigenerational families than other ethnic groups and are more likely to live in larger families than other ethnic groups [2]. However, within the joint family, Asian American children, even adult children, are often expected to act in accord with their parents' wishes and family cohesion is viewed as valuable [35]. For example, a South Asian couple living with the husband's parents in Chicago might discuss vacation plans with the husband's parents before making arrangements for a flight to ensure that they approve.

Clinical Example

As the intake social worker at an urban psychiatric clinic in New York City, you receive a phone call from a Korean man working temporarily in the United States. He asks that you evaluate his wife who has been very upset about failed infertility treatments. Her infertility specialist recommended that the wife have a mental health evaluation after her last treatment did not work. You arrange an initial meeting with the couple. During the first visit with the couple, the husband describes much of the wife's history and the couple's immigration history. The wife occasionally disagrees with the husband but mostly remains silent. The couple expresses how sad they are about being unable to conceive another child. Because they have been afraid of disappointing their extended family, neither wife nor husband has discussed their trouble conceiving with any family members, who continue to ask them why they have not had a second child. Their extended family expects them to have other children by the time they return to Korea. Both husband and wife are worried about returning to live with the husband's parents and the shame they will face for not having another child. The husband agrees that the wife will come to meet with you for the second visit alone.

The interdependence of family members among Asian Americans manifests itself in various ways, one of which is when Asian Americans contemplate making major life decisions, such as choosing a career, buying a home, or selecting a spouse. Another way in which the interdependence of Asian families reveals itself is in how families react to the actions of one member of the family. Often behavior of one family member is considered to be representative of the family as a whole to the rest of society. Families may value academic and occupational achievement of their children as bringing honor to the family in part for this reason. On the other hand, behavior against the family or cultural values, such as a delinquent behavior, a suicide attempt, being gay or lesbian, or taking a partner from a different religion or ethnic background may be viewed as bringing shame to the family or causing the family to "lose face" and lead to conflict within the family [41, 43].

Cultural values of displaying more tempered emotions and family harmony may lead to more indirect or restrained communication between family members than in non-Asian American families [35, 43]. Additionally, the emphasis placed on respect and obedience to parental authority can also decrease the likelihood of open communication between different generations, particularly when there is conflict [43]. Acculturation differences between generations as detailed in the next section in Asian American immigrant families may also be a cause of problems in family communication. Acculturation and enculturation are related concepts. Both reflect aspects of the process of change an individual undergoes when he moves to a new culture. In acculturation, this change reflects affiliation with the new dominant culture; in enculturation, this change reflects affiliation to the individual's old culture. Dissonant acculturation, which will be reviewed below, reflects how the process of acculturation may cause tension within a family.

Acculturation and Families

Connections among family members undergo transition as immigrants move to a new culture and attempt to adapt to the culture. In a process known as acculturation, the individual adapts with regard to identity, beliefs, and values in relation to the new dominant culture [44]. Enculturation, a related concept, functions in the opposite manner and is a process in which a person strengthens their ties to social norms and values of their culture of origin [44]. Hwang has referred to the term acculturation family distancing (AFD) to encapsulate the difference between the parent and child generation in immigrant households who may acculturate at different rates, leading to a difference in values and also difficulties in communication [35, 45]. Other researchers have referred to this phenomenon as "dissonant acculturation" and believe this is particularly relevant in conflict between parents who may struggle to maintain ties to the old culture and children who because of their age and desire to connect with peers may have greater exposure to the new culture [44]. For example, while the parents in a family may struggle to learn a new language and understand new cultural values, the children in a family may more rapidly acculturate to the new culture due to increased exposure to the dominant culture at school. For example, an immigrant child in middle school may learn English more quickly than his or her parents because of ESL (English as a second language) classes. The child may learn styles of dress and about current popular music from her peers. The child may also see how her non-Asian peers interact with their parents and try to adopt that style of communication or rebel against values that she had previously accepted in her family. Areas in which different values may cause greater conflict include how different generations communicate or make choices about appearance, sexuality, education, careers, home ownership, and marriage.

This acculturation gap can also occur between elderly relatives that are coming from the country of origin to live in the United States with their children. Grandparents may be brought to the United States with the idea that they can benefit from better health care or provide childcare for the family. Immigration is often alienating for older immigrants, who likely face greater functional limitations and language limitations than younger generations [35, 46]. It is also more challenging for the elderly to establish a peer group, and a grandparent new to the United States may experience an acculturation gap with their children and an even greater one with their grandchildren.

Acculturation is part of the process of making a cultural and geographic transition and can lead to significant intergenerational conflict in Asian American families. As will be discussed in the treatment section, this type of conflict can be quite distressing in families that value loyalty and harmony and may lead to Asian Americans presenting to mental health treatment.

Engaging Asian Americans in Treatment

As with any initial encounter with a patient, it is important for the clinician to understand the nature of the Asian American patient's problem and to start to formulate an approach to help the patient with his or her difficulty. Given the importance of family, a mental health clinician or researcher should be prepared to have multiple family members present for any or all of an initial appointment or assessment [47]. Additionally, the clinician may at first consider primarily communicating with the family member in position of authority, if this seems in keeping with the family dynamic, even before the appointment and during the appointment itself. In addition to the usual information gathered in an intake, the clinician should strongly consider asking about the patient's and family's immigration and trauma history, cultural background, religious beliefs, patient and family's acculturation experiences, and the patient and his family's belief about the etiology of his problem and about what other forms of treatment or help the patient and his family sought or are seeking. As with other patients, traumatic parts of their history, including migration, violence, abuse, political conflict, and suppression, may require more detailed and sensitive inquiry to fully bring to light.

The hierarchy in the family may be clear to the clinician in the first contact with the patient's family, whether on the phone or in person, and is important to respect in creating an alliance with the patient. A clinician may have to pay extra attention in a meeting with a family and observe who sits down first and who speaks first and whose opinion most family members defer to. For example, the husband in a Bangladeshi couple may first contact the clinician to set up an appointment for his wife and join the clinician and his wife for the initial intake appointment. When treatment options are given, the patient may look at her husband for guidance before expressing an opinion. In another family, the most elderly member of a family may be a mother, and her adult children may defer to her for decision-making.

Many Asian Americans may view the clinician as an expert or an authority and may feel that it is impolite to express disagreement or ask too many questions of the clinician. Patients may overtly exhibit deference to authority in a variety of ways: calling all clinicians "doctor," avoiding direct eye contact, profusely thanking the clinician or bowing, or bringing the clinician gifts [47]. Patients may feel more comfortable with the physician or mental health clinician being authoritative rather than joining with the patient and their family in a more collaborative manner and sharing decision-making with the patient or family. It is possible that Asian patients may expect the clinician to act more as the model of the paternalistic healer [47]. Patients may covertly express disagreement or dissatisfaction with the recommendations of the clinician by remaining silent and not contradicting the physician's advice or accepting a prescription but not filling the prescription or taking medications. While silence in Western cultures may be viewed as tacit assent, with Asian American patients, silence can mean dissent [47]. For clinicians, it is important to not assume that lack of direct eye contact is indicative of paranoia, disengagement, or social anxiety and also that silence means that the patient completely agrees with the treatment recommendations and will follow them. Patients or family members may ask personal questions of the clinician to humanize the clinician and relate to her as a trusted elder or family member, to assess his cultural knowledge, to ensure that the clinician does not know others in the patient's community due to worries about confidentiality, or to find out if the mental health practitioner will judge the patient for their difficulties. Some patients may more explicitly express seeing the clinician as a role model, particularly if the clinician has some overlap in background with the patient or family. Like with all patients, some Asian American patients, as described later in the stigma section, may be fearful about seeing a mental health practitioner out of worry that this may mean that they are insane or that others will find out that they have seen a psychiatrist and this will bring on shame for his or her family.

Some Asian Americans may have limited English language proficiency, which can pose a challenge for the patient, their family, and the mental health professional. There is very limited data on the use of professional interpreters and nonprofessional (family or friends) interpreters or cultural brokers in Asian American patients, both in medical and mental health settings. One study of over 2000 Chinese and Vietnamese immigrant adults at community health centers in the United States found that patients who used interpreters compared to those who had a clinician who spoke the same language were less likely to ask questions about mental health [48]. In this study, patients who rated their interpreters as high quality were also more likely to rate their overall health care as being of high quality [48]. The data from this study suggests that Asian American patients may feel more comfortable with a clinician who speaks the same language rather than using an interpreter, particularly for asking about mental health problems. However, it is very difficult to make generalizations about the use of interpreters, cultural brokers, or language concordant professionals with the heterogeneous group of Asian Americans based on only one study. Another 2018 study from a community mental health center in the Southwest found that ethnic and language matching of Asian American patients and counselors predicted completion of a course of counseling as well as number of sessions attended [49]. Again, this is an area that merits further exploration. It is not clear that the results can be generalized to the heterogeneous members of the group that comprise Asian Americans. Additionally, the study authors point out that it this kind of matching is not possible in many treatment settings.

I have included some basic guidelines for the initial encounter summarized in Table 10.3 from my experience and the collective experiences of colleagues working with Asian American patients over the last 8 years in urban settings in the emergency room, inpatient unit, research setting, and private practice. As described earlier in this chapter, it is important to not make assumptions about the patient and their personal narrative based on the general principles in this chapter but rather to use these principles as framework for understanding the patient and how their present situation came to pass.

Table 10.3 Ten tips for the initial encounter with an Asian American patient

1. Expect and welcome family participation in the initial evaluation, possibly from several generations
2. Ask detailed questions about the patient and family's health beliefs
3. Ask about what treatments they have tried, both Western medical and traditional treatments, and what they are currently doing to improve their condition
4. Obtain the patient and family's immigration and trauma history
5. Plan for the initial appointment to be mostly structured by you and somewhat formal. It will likely help the patient feel more comfortable with your authority
6. Do not be put off by a patient's limited eye contact or deferential manner if this occurs
7. Be sensitive to family conflicts and intergenerational conflicts as a possible reason for the patient's seeking treatment
8. Remain mindful of the mind body connection as you ask questions and recommend treatment for the patient
9. Remain open to the integration of the patient's traditional healing methods and what you recommend
10. Do not assume that a patient upholds to a particular religious or cultural belief; make sure to ask about it! As with every patient, each patient is a unique individual

Psychopharmacology

Studies have shown that Asian Americans may benefit from initial lower dosages of medications than White populations and may require lower doses for therapeutic effect. These ethnic differences have been attributed to pharmacogenetic differences in the cytochrome p450 system, a system of enzymes responsible for metabolizing psychiatric and other medications. Other factors, such as smoking, diet, age, gender, and use of other medications, may also impact effective plasma levels of psychiatric medications. Henderson et al. provide a very thorough review of ethnopsychopharmacology in different minority populations [50]. While there is limited data on ethnopsychopharmacology in persons of Asian descent, it is worthwhile to examine the relevant findings and consider how these findings may impact mental health research and treatment of Asian American populations.

With regard to the cytochrome p450 system, the metabolic activity of particular isozymes in this system has been shown to be lower in Koreans, Chinese, and Japanese compared to Whites [19]. In particular, a third of Asians are homozygous for a particular mutation, CYP 2D6∗10. This mutation leads to slower activity of the CYP2D6 enzyme that metabolizes traditional antipsychotics and tricyclic antidepressants [19]. This indicates that an Asian American patient with this mutation may need a lower dose of an antipsychotic or tricyclic antidepressant to achieve the same therapeutic blood level of a medication when compared to a patient of another ethnic backgrounds. Additionally, approximately 20% of persons of Asian descent may have a mutation of CYP2C19 called m2. This mutation causes 20% of Asians to be poor metabolizers of the benzodiazepine diazepam compared to 3% of White persons [19]. Another study by Lin showed that both foreign-born and US-born Asian Americans responded to lower doses of alprazolam than Whites [51]. In this study, there was no difference in the response to the medication between foreign-born and US-born Asians, which suggests that the difference between Whites and persons of Asian descent was pharmacogenetic [51].

Nongenetic factors also impact the activity of various isozymes of the cytochrome p450 system. For example, the activity of isozyme CYP1A2, involved in the metabolism of typical antipsychotics, olanzapine, clozapine, amitriptyline, clomipramine, nortriptyline, mirtazapine, and fluvoxamine, can be induced by the consumption of char-broiled beef and a high-protein diet, which may be consumed by particular East Asian populations [19]. The activity of another isozyme CYP3A4 is notably inhibited by consumption of citrus fruits and corn [19].

There may be other differences that account for differing response to psychiatric medications in Asians. For example, treatment with lithium in East Asian populations yields a therapeutic effect at levels less than 0.8 meq/mL [19]. The author of the review, Lin, suggests that this could be due to pharmacodynamic factors, factors related to the effect of a specific medication on the target organ. Another study from 1988 examines the differences in serum haloperidol and serum prolactin concentrations in White, American-born Asian, and foreign-born Asian American volunteers. This study found significant differences between patients of Asian descent and White patients in both serum haloperidol levels and prolactin levels, suggesting both pharmacokinetic differences and a possible difference in dopamine receptor-mediated response to the medications [52].

Asian Americans, because of potential slower metabolism of medications, may be more sensitive to side effects of medications or have toxic reactions to medications prescribed at recommended doses [53]. A study of desipramine pharmacokinetics in White and Chinese volunteers found higher clearance of desipramine in White volunteers compared to Chinese volunteers when controlling for body weight. The authors suggest that treating Chinese patients with standard doses for desipramine would put these patients at greater risk for toxicity [53]. A general approach to prescribing psychotropics to Asian American patients may be to “start low and go slow” as with geriatric psychiatric patients who are often started at half the typical dose of medications and monitored closely for and educated about side effects. It may also be worthwhile to get blood levels of medications to assess whether or not a patient is a normal or slow metabolizer after an Asian American patient has been on a steady dose of medication for several weeks (Table 10.4).

With regard to psychoeducation, as with all patients, it is helpful for Asian American patients to know that antidepressants and mood stabilizers take weeks to work and antipsychotics take days to work. Some Asian American patients may be more likely to believe that medications should be short term and work quickly, based on traditional beliefs [54]. For these patients, it is very important to understand the difference between medications that work quickly like benzodiazepines and stimulants and ones that they need to remain on for longer to achieve their effect. Patients may not be familiar with how psychotropics work and may need psychoeducation that involves reframing the purpose of the medications in a culturally sensitive manner. For example, in the treatment of a Southeast Asian refugee with severe PTSD and depressive

Table 10.4 Medical class-specific considerations for Asian American patients [50, 52]

Tricyclic antidepressants	Start at half of regular starting dose Watch for toxicity and side effects, even at low doses May need lower doses of therapeutic effect
SSRI, SNRI, and other antidepressants	Lacking data in Asian populations
Haloperidol	Lower doses used with effect More likely to have higher blood levels than in other populations
Clozapine	May have efficacy with lower dosage (169 mg/day) May have more risk of agranulocytosis
Atypical antipsychotics (olanzapine, risperidone)	Limited data suggests that Asian patients may have higher blood levels than other populations
Benzodiazepines (alprazolam, diazepam)	Slower metabolism in Asian populations Higher blood levels than in other populations
Lithium	Lower doses in East Asian populations yield therapeutic levels

symptoms, a clinician may explain that the patient's symptoms are due to an excess amount of stress and not due to a brain problem and that the medications may help the patient eat and sleep better [55].

Psychotherapy

An Asian American patient may expect a more pragmatic or directive approach in therapy initially due to viewing the clinician as a wise authority figure and may want advice or feel uncomfortable with an unstructured session. Like with other patients, their openness to participation may depend on how much the patient knows about psychotherapy and its purpose and also how comfortable they feel expressing their feelings and bringing up potentially shameful or painful topics. As with any patient, it is worth considering cognitive behavioral therapy as well as dynamic approaches, depending on the nature of the presenting problem. CBT approaches to PTSD and group therapy approaches in Southeast refugees have been very successful, focusing on pragmatic strategies for managing life and also helping patients understand and manage their symptoms [55]. Additionally some clinicians have also developed psychotherapeutic treatments for cultural syndromes, such as a nursing treatment program designed for patients with Hwa-Byung that incorporated drama therapy, music therapy, and group therapy to help patients express anger. This was more effective treatment for the patients than the control condition [56].

Some authors have suggested the use of traditional stories or parables in psychotherapy with less acculturated patients who may have less difficulty talking about conflicts or symptoms in displacement [47]. Other patients may be willing and suitable for engagement in a more insight-oriented or exploratory treatment and may benefit tremendously from it as stated above [57]. Some members of a family may be more open to participating in psychotherapy if they know another family member who has benefitted from it. A 2016 survey study of attitudes toward psychotherapy of Asian Indian parents in Texas, California, Ohio, Maryland, and Florida showed that parents who had previously undergone psychotherapy had more of a positive attitude toward their children potentially getting psychotherapy compared to parents that had not. Asian Indian mothers were more open than fathers, additionally [58]. As mentioned above, a study from 2018 demonstrated that ethnic and language match between clients and therapists predicted successful completion of psychotherapy, when socioeconomic status and acculturation were controlled for, in a diverse Asian American outpatient population [49]. The concept of client/patient matching remains an area that requires additional study among Asian Americans.

Paying attention to the use of defenses like with all patients can help the therapist initially determine how to engage the patient, as well as sensitivity to family dynamics. In my clinical experience, it has been notable that themes of separation and individuation may present themselves prominently for adults of Asian American backgrounds due to some difference in emphasis on autonomy and individuality in Western and Eastern cultures. There have been some excellent case studies describing the details of different Asian American patients in psychotherapy [57, 59]. Determining a psychotherapeutic approach is very individual specific and will be addressed further in the clinical cases section at the end of the chapter.

Inpatient Treatment

A psychiatric hospitalization is a major event for every patient and family. Asian American families may be misinformed or have misconceptions about mental health treatment for these conditions based on inhumane conditions at treatment facilities in their country of origin of their family's country of origin. They may be more likely to perceive hospitalization as abandoning the patient [60]. Families from any cultural background may also feel it is their duty to care for a family member with mental illness, but the culture value of filial piety may lead to care giving at home being more of a cultural obligation for

Asian Americans [61]. As in all populations, Asians Americans will have the same worries about diagnosis and prognosis for the patient. The clinician also has the responsibility of giving the patient and the family hope, a realistic prognosis, and reassurance that these illnesses are treatable.

Because many Asian American families are interdependent, it can be very helpful for the patient's treatment to include multiple family members in family meetings in the hospital, to meet with the entire family while the patient is inpatient and when planning to transition to outpatient settings for culturally sensitive psychoeducation. Additionally, it may be helpful to have regular contact with the head of the family when needed and for the treatment team to consider the family as part of the patient as well. It also may help with adherence to specifically discuss the purpose of treatment of medications with the patient as well as the family and discuss issues related to stigma and shame directly in a matter of fact manner. For example, the treatment team can emphasize the biological etiology of mental health conditions and directly state that a mental illness is not anyone's "fault." The treatment team can also incorporate any relevant complementary or alternative treatments to further build alliance with the patient and family.

Integration of Traditional Medicine and Western Approaches

Some patients may wish to pursue traditional treatments in addition to or instead of their treatment with their mental health practitioner, whether it involves consulting with a shaman for exercising bad spirits, acupuncture, meditation, acupuncture, Ayurvedic or root medicine, tai chi, or other traditional treatments. Before suggesting allopathic psychopharmacologic or psychotherapy, asking about what traditional treatments the patient has tried would be valuable. Furthermore, some knowledge or willingness to learn more about these treatments will aid the mental health professional in understanding the patient's problem more deeply [60]. In an article about working with Asian Americans in a culturally sensitive way, Park et al. detail the example of a psychiatrist working with an Asian American psychotic patient who sought consultation from a herbalist about herbal treatments for psychosis to educate the family of the patient along with the treating psychiatrist [60]. For example, knowing that a patient with panic disorder incorporates meditation into her daily life may help a psychologist consider a wide variety of treatments for overwhelming anxiety and fear, including mindfulness-based cognitive behavioral therapy, relaxation exercises, dialectical behavioral therapy, as well as the more traditional route of cognitive behavioral therapy for panic disorder.

Mental health clinicians may have a skepticism to nonevidence-based treatment or feelings of discomfort by the patient's pursuit of alternative treatments and may view it as a challenge to their authority or disbelief in science on the patient's part. While Asian American patients may view the Western-trained clinician as an expert or an authority, the clinician has little to lose in the eyes of the patient by being open and flexible about alternative methods of treatment and the unique way in which the patient conceptualizes his or her difficulty. A dismissive reaction could be alienating to some Asian American patients; however, other Asian Americans may not be interested in pursuing traditional treatments at all or may have exhausted them already.

If a practitioner is prescribing medications to a patient, it is important to check with the patient about whether or not they are taking any traditional medications, teas, or supplements and to ask about their diet to ensure that there is not any interaction between any of their treatments [60]. In the primary care setting, it is important to include questions about culturally traditional treatments and practices in initial appointment paperwork with questions about the patient's other medications. This is important for a culturally sensitive approach but also to ensure the safe integration of traditional and allopathic treatments. Also, in the initial visit of an Asian American patient to any medical specialty, surgical clinic, or research assessment, the nurse practitioner, social worker, or physician should also consider that somatic symptoms may be a manifestation of a mental health problem or cultural syndrome.

Stigma, Shame, and Denial

As previously described, Asian American populations underutilize mental health services compared to other ethnic populations. Canadian researchers in a 2017 study found that patients of East and South Asian origin with psychosis were more likely to present to the emergency room under involuntary detention when compared to patients of White European, White North American, Black Caribbean, or Black African origin [62]. This suggests that in addition to other barriers to accessing services, Asian Americans may delay seeking psychiatric services for themselves or a family member to the point that the patient's condition may have become very serious [19]. Additionally, if Asian American patients may tend to present under more coercive circumstances, the potential for alienation from the mental health-care system could be quite high, as contact with emergency psychiatric services can be quite scary or overwhelming. Additionally, when mental health is discussed in the primary care setting, aspects of stigma continue to be present in the mind of some patients. A study of Chinese American patients in a Boston primary care clinic in 2015 showed that, compared to a prior study, these patients were more likely to describe symptoms related to depressed mood than somatic symptoms but were more likely hide the cause of these symptoms from others compared to the prior sample [63]. This study suggests that while Western frameworks for understanding depressive symptoms may be on the rise, stigma has risen as well.

Delays in seeking treatment may be related to the stigma of mental illness in Asian cultures and an effort to ward off shame for the patient and his or her family [64]. For example, a young South Asian American man with a psychotic illness at a city hospital told his treating physician that he had been off antipsychotics for months while living at home and was paranoid to the point that he was hoarding his urine and excrement at home with his physician parents. In this case, the patient's parents may have believed that seeking treatment for their son in a small community would bring about shame to their family, and the denial of his illness may have helped to preserve their good image of themselves or their son. A family may believe that the illness is because of karma and telling mental health professionals that a family member is ill may reveal that a family member may have acted badly in a past life. This case illustrates that stigma may be felt by the family as well as the patient.

However, while stigma is often perpetuated by the society or community that surrounds the patient, family members can also perpetuate stigma by shaming a patient about their illness, not encouraging them to disclose their illness, and criticizing the patient about being lazy and not working, for example. A 2015 study of stigma experiences of Chinese immigrant patients with psychosis in New York City revealed a high prevalence of stigma perpetuated by family members of Chinese patients with psychosis. The researchers found this finding particularly striking, as many patients have to rely on family for social and economic support and yet feel quite stigmatized by them [65]. Stigma may also be influenced by the age of the individual. Family stigma was among the significant contributing factors to the underutilization of mental health services by young Asian American women with a history of depressive symptoms and suicidal behavior, a particularly high-risk group [66]. One study found older Korean Americans were more likely than younger Korean Americans to view depression as character weakness bringing shame to the family [67]. Taken together, these studies suggest that stigma within the family can be a significant barrier to accessing mental health services for Asian Americans.

For some communities, in which there is a tradition of arranged marriages or family-brokered unions, like also in the Orthodox Jewish community in which mental illness is very stigmatized, the idea of revealing that a family member has a psychiatric problem may taint marriage prospects not only for the patient but also for their siblings or for generations to come [68]. For the individual's community, the acknowledgment of psychiatric problems may represent a character defect or genetic defect in the person or in the family or person.

Along this same vein, it may be difficult in the treatment setting to obtain an accurate family history due to stigma. Family members may not tell the clinician about other relatives in the family with mental health diagnoses. Furthermore, the stigma can be so powerful in families that in some cases a patient may not have even shared with his or her spouse that there is mental illness on his or her side of the family and at times a patient may have no idea that he or she has a relative with a psychiatric problem.

This level of shame may lead to difficulty accessing treatment for the patient and family and even may result in a family colluding with the patient's own resistance to getting desperately needed help [60]. For example, a mother may minimize her child's hyperreligious manic behavior of disrobing publicly and giving away all of his money as a part of a religious ritual not understood by doctors from a different culture and insist that her child does not have an illness. The family might support the patient's wish to be discharged from the emergency room, despite the patient's extreme difficulties with functioning. A physician parent may take over prescribing antipsychotics for his or her own child and misdiagnose them with an anxiety disorder. Families may even send a mentally ill family member to relatives in a different country to live with them in the hopes of a geographic cure to maintain denial and escape questioning of others in their community.

It is also possible because of shame and stigma that patients with trusted relatives or friends who are physicians or mental health-care professionals may have been asked to treat the patient or advise on his or her care in an informal way. While this behavior could be seen as culturally acceptable or preferable, for the patient it may be difficult to be as open with a person in their social circle and may make it difficult for the patient to get an accurate assessment of their difficulty. It is also possible that in some communities, particular diagnoses, like bipolar disorder, schizophrenia, or substance abuse, may be more stigmatizing than others. For example, compulsions related to hyperreligious obsessions related to cleanliness may be more acceptable in some communities than other psychiatric symptoms.

Intergenerational Conflict

More traditional Asian American families may try to minimize conflict within the family or be ashamed about revealing the layers of family conflict to the treatment team or professional. In particular, a parent may be quite distraught about a child making choices that conflict with the family's cultural values and may feel ashamed to discuss this in the health-care setting. A parent may manifest their distress in indirect ways, such as somatization or other symptoms, and may present in the primary care setting. Similarly, children with aging parents may be extremely uncomfortable or feel disrespectful if they question an elderly parent's cognitive abilities or their behavior to make decisions. They may try to save their parents shame in front of the professional and either minimize difficulties or contact the professional later to be more honest with them. Family conflicts may take a great toll on Asian Americans, and there is growing evidence to suggest that conflicts may themselves be a significant contributing factor to mental health difficulties at different life stages.

Intergenerational conflict has mental health consequences for the Asian American family as a whole. Greater intergenerational conflict and acculturation gap have been found to correlate with poorer mental health in Asian American college students [69]. Asian American families are particularly at risk of a surge in intergenerational tension as the younger generation enters adolescence. While in Western culture, adolescence is associated with rebellion and individuation from parents, in most Asian cultures, adolescence is associated with increased responsibilities and continued obedience to parental authority with regard to important decisions. This gap in values in expectations can be a major source of conflict between Asian American parents and children and can lead to tension, depression, anxiety, and suicidal ideation in children and adolescents [43, 70]. One study showed that intergenerational cultural dissonance was significantly positively correlated with increased alcohol use among Cambodian and Vietnamese youths from immigrant families in Washington State [71]. On the other hand, more support from adult family members has been negatively correlated with depressive symptoms in Asian American adolescents [72].

Intergenerational conflict can also be very difficult for parents and for aging adults. One study showed increased depressive symptoms in Korean American parents with young children. Conflicts around the child's social life, expressions of love, disagreements about proper children's behavior, and the notion of saving face were most associated with parental depressive symptoms [73]. Aging Asian American adults also face a similar impact of tension between generations. Analysis of data from the Population Study of Chinese Elderly in Chicago demonstrated that difficult relationships with adult children were correlated with increased severity of depressive symptoms, whereas more supportive relationships with adult children were associated with less severity of symptoms of depression [74]. Given that intergenerational conflict is associated with psychological distress and depression, this would be a good target for mental health interventions across the lifespan in Asian Americans.

Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBTQ) Asian Americans

While Asia has made more progress in the last 10–20 years of having more openly homosexual populations, individuals who are lesbian, gay, bisexual, transgendered, or questioning (LGBTQ) are still often highly discriminated against, marginalized, and can be subject to violence in Asia. While, in the United States, LGBTQ individuals have found increased acceptance in recent decades, Asian cultures lag far behind in this respect. Some areas that have a reputation for being LGBTQ friendly include Nepal, which hosted the first Asian Symposium on Gay and Lesbian Tourism in 2010, Bangkok, Shanghai, and Manila [75]. Because of values of the importance of Confucian, Hindu, and Islamic values about gender roles, marriage, and family lineage, homosexuality is still as unacceptable in many families of Asian origin [76]. Families may feel that having a homosexual child brings shame to the family and makes them subject to social judgments. Parents may accept their child's sexuality within the family, but they may strongly pressure a child not to be open about their sexuality to extended family. Additionally, while they may accept that their child is gay or lesbian, they still may pressure the young adult to marry so that they can save face among the extended family and community. Furthermore, there may also be pressure on the individual to get married in order to have children to continue the family lineage.

Sexual minority Asian Americans may struggle to feel accepted and may be forced to choose between gaining support of the LGBTQ community or their ethnic community, though there are increasingly more available resources for LGBTQ Asian Americans [76]. One study compared the utilization of mental health resources by heterosexual and homosexual and bisexual Chinese American, Vietnamese American, and Korean American "1.5-generation" women and second-generation women found that the sexual minority women had no more barriers to accessing care than heterosexual women. The researchers hypothesized that this may be because these sexual minority women may be more open to seeking out mental health services because of the combined difficulties they face belonging to both an ethnic minority population and a sexual minority population [77]. However, this increased ability to seek out care may also suggest that the mental health burden is higher on these patients who belong to multiple minority groups.

Racism and Mental Health

Asian Americans are subjected to bias and aggression due to their appearance, country of origin, language, accent, migration history, citizenship status, and other factors related to stereotypes about their culture, including diet, clothing, customs, marital practices, and style of speech. Microaggressions related to race have been associated with depression, somatic symptoms, negative affect, and traumatic symptoms in Asian Americans [78–80]. In recent years, more research has been devoted to studying microaggression as well as ways to cope with racism. A 2018 study of Asian American and Latin American college students demonstrated an association between racial microaggression and psychological distress. This study found that those affected students who utilized engaging coping strategies, such as turning toward others for support in their social system, mitigated the risk of depression and negative mental health outcomes, as opposed to strategies that involved distancing themselves from others [78].

Interestingly, another study of foreign-born Chinese, Vietnamese, and Korean Americans in Baltimore found that everyday experiences of discrimination were more likely to be associated with depressive symptoms than major experiences of discrimination, perhaps due to population-specific factors that may have been difficult to tease apart in this study. In this study, three out of every five subjects reported having any experiences of discrimination, and one out of every five subjects reported having a major experience of discrimination [81]. The researchers hypothesized that a language barrier may have prevented some participants from accurately categorizing acts of discrimination toward them as major experience of discrimination.

A cross-sectional study of older Chinese Americans in Chicago indicated that discrimination was statistically significantly associated with depression, independently of other factors, such as socioeconomic variables and personality factors. This study also showed that more acculturated older Chinese Americans living outside of Chinatown with higher socioeconomic status and acculturation were more likely to report discrimination [82]. From this data, it is not clear if these individuals had more contact with non-Chinese persons and were more likely to be subjected to depression or whether they were more cognizant of the value of equality in American society and were more likely to recognize when discrimination had taken place [82]. Taken together, these studies reinforce anecdotal experiences heard in clinicians' and educators' offices that bias experienced on a daily basis can erode self-esteem and mental health in Asian Americans. It is imperative that professionals working with this population take these experiences seriously and not minimize them when hearing about discrimination from a student, patient, or research subject.

Abuse/Trauma

As a clinician, educator, or researcher working with Asian American populations, it is critical to be alert to histories of trauma to understand one's patient or research subject. There are many subgroups within Asian American communities that have experienced traumatic incidents on a wide level including the Vietnam war, repetitive sexual assault as comfort women in Korea, Japanese interment in the United States, human trafficking for prostitution or domestic slavery, and Cambodian Civil war, imprisonment, and torture under repressive governments [47, 55]. These experiences, which may not be easily disclosed clearly, impact mental health.

A 2016 study based on the NLAAS data showed that Asian immigrant groups, except for the Vietnamese, with pre-migration trauma, which included political trauma, crime victimization, physical violence, accidents, life-threatening trauma, and vicarious trauma, all were more likely to have psychological distress post-migration. This post-migration distress was often experienced through perceived discrimination [83]. This study indicates that there is a significant link between the experiences of Asian Americans prior to immigration and their mental health upon arrival and adjustment to their new country. Experiences of discrimination in the United States may compound traumas in the past of these patients. When compared to White, Hispanic, and Black groups, another study found that Asians who experienced childhood mistreatment and interpersonal violence were mostly likely to report suicidal ideation when compared to the other groups [84]. While more research needs to be done in this area, it appears that traumatic experiences may put Asian Americans particularly at risk for mental health difficulties.

Patients may or may not initiate a discussion about these experiences due to shame and stigma, though they may exhibit some symptoms of PTSD or maltreatment on exam (see section Case 1). A 2018 study of the impact of 9/11 on Asian Americans indicated that, compared to Caucasians, Asian Americans had a higher prevalence of PTSD. The prevalence of PTSD in this population was also higher than that of the first responders and civilian survivors from the towers, suggesting a greater vulnerability to PTSD in this population [85]. One wonders if the persons in this study had higher levels of trauma in their backgrounds as well. Trauma may also happen on an individual level, and patients may feel ashamed about discussing these issues with the clinician for fear of bringing shame onto their families.

Traumas common in Asian American households include domestic violence, incest, rape, sexual abuse, physical abuse, and verbal abuse [47]. A patient may have difficulty identifying abuse in the home as abnormal or traumatic and linking this history to their present symptoms. A 2016 survey study of South Asians in America found that 25.2% of respondents reported a history of childhood sexual abuse and 41.2% reported witnessing parental violence and 24% described a history of experiencing violence in their own adult relationship. This study, among many others, demonstrated an association between suicidal ideation, childhood sexual abuse, and a history of violence in relationships [86]. For example, an Indian American patient with depression, promiscuity, and emotional outbursts may not readily identify her mother's physical and emotional abuse of her as a child as connected to her difficulties with mood regulation and difficulties establishing friendships and intimate relationships. In these cases, it is up to the careful clinician to explore these issues sensitively and to decipher the meaning behind the patient's description of their experiences and to help the patient understand and contextualize their childhood experiences.

To help the reader synthesize the information in this chapter, the complexities of what was just discussed is illustrated in these blended cases (to protect patient privacy) based on the chapter author's (SA) own clinical work, consultations with experts, and the cases of colleagues in clinical, educational, and research settings.

Case Vignettes

Case 1

A 34-year-old Cambodian male presents for an assessment of depression as a referral from his male psychotherapist who he has seen off and on in the past 5 years. He was previously treated with fluoxetine and bupropion but felt that his past psychiatrist was too aggressive in increasing the doses of medications and wants to be only on one medication. He has been socially isolated, not eating adequately, and not managing his finances; he is also worried about being judged for making too much noise by his neighbor next door and incredibly anxious about trying to date women. After meeting with him and discussing his case with the therapist, he is started on escitalopram. The dose is increased over 2 months, until the therapist reaches out to the psychiatrist about the patient's suicidal thoughts. The patient revealed these thoughts to the psychotherapist, but not the female psychiatrist.

After the patient's regimen changes to venlafaxine and the dose is increased in conjunction with the therapist's ongoing concern about the patient's functioning, the patient again has a worsening of symptoms and a severe episode of suicidality. In this episode he contemplates hanging himself and takes out a belt. This happens on a day when there is a mix-up about his refill with the pharmacy, and he becomes agitated and angry and cannot calm himself down. He is without medication for 2 days and does not reach out to the psychiatrist. In speaking with his therapist about this episode, which does resolve, he describes in more detail being locked into a closet at home as a young child when upset and having intense tantrums as a result. He describes having a flashback about being locked in the closet while he was experiencing medication withdrawal. While each of his five siblings may have experienced this punishment, he is the only one in treatment, and his family makes fun of him for being weak.

Discussion

Diagnostically, the clinicians both initially strongly considered diagnoses of major depression and social anxiety disorder, given the patient's prior history of depression and neurovegetative symptoms, and also his history of anxieties about being judged by the neighbor, as well as his difficulties related to self-esteem in dating.

In particular, due to the patient's Asian background and presentation, the clinicians did ask about the family's immigration history and had a sense of the traumas that the family had experienced as refugees to the United States after the Khmer Rouge seized power. While there was some sense of these experiences and their impact on the family, the patient minimized his experience of physical and emotional abuse in the family, as this had been "normal" for him. It was also invalidated by his other siblings and parents. The depth of the traumas the patient experienced in his family, perhaps in part related to traumas experienced by his parents, made his clinicians consider intergenerational transmission of trauma in his family and how such trauma was perpetuated in the patient's generation. In his family, there was the belief that the children had it much easier than their parents after immigrating to the United States.

This leads to the psychiatrist and psychotherapist to consider the diagnosis of post-traumatic stress disorder as a contributing diagnosis to the patient's symptoms. They also reflected on what kinds of treatment might be more beneficial for the patient, including mind-body treatments, like yoga or meditation, in conjunction with psychotherapy and medications. It also helped the psychiatrist understand why medications may not have been as effective in treating this patient, as PTSD may not have been adequately addressed. Also, the psychiatrist wondered if the patient was less open with her in part because the abuse was mostly at the hands of his mother, and the patient may have felt uncomfortable revealing vulnerability to a female authority figure.

The psychotherapist also discussed with the patient how being "weak" made the patient feel like he did not conform to more traditional views of Asian masculinity and also contributed to his feeling like the scapegoat in his family. The two clinicians discussed referring him to a trauma group or a trauma-focused psychotherapist who had worked with a refugee population.

Case 2

A 45-year-old Bangladeshi woman presents to her primary care physician's office in tears and with headaches and difficulty eating and sleeping. Her physician, who has treated her for the past 5 or 6 years, is very surprised as the patient normally seems very well put-together. The patient works for a reputable nonprofit organization. She has a husband who works in financial services and a 3-year-old daughter. The patient had conceived her daughter through IVF some years earlier, as she believes her husband is a closeted gay man, though they have never directly discussed this. They have never had a sexual relationship but decided to have a child together.

While she was very depressed before the pregnancy and throughout the pregnancy, she has been very delighted to be a mother. She notes that the problems in her marriage have worsened since the child was born, and she has not slept in the same bedroom as her husband for the past 3 years. Her husband gets upset with her if she leaves the house to get a haircut as he wants her to be fully responsible for the child and always puts his work first.

She decided 2 years ago that she wanted to try to have another child, which her husband tolerated but did not really support. She was pregnant earlier this year but had a miscarriage 5 weeks ago. Since then, she has felt her mood go "off a cliff." She has been crying nonstop and feels that she cannot get anyone to understand how badly she feels. She tried getting comfort from her mother, who lives in the same city, but her mother told her to be strong, that the child was not actually born, and that perhaps she deserved this from something she had done in her past life. The patient feels blamed by her husband who was not in favor of a second pregnancy. She does not know what to do. She does not want to go to work today and has suicidal thoughts but feels that she would not want to hurt her daughter.

Discussion

The primary care physician (PCP) is very concerned about this patient and immediately does a risk assessment. While she promises him that she will not hurt herself right now and denies any intention of doing so, he asks if she would be willing to go to the emergency room to get more quickly connected to psychiatric services. With the patient's permission, the PCP leaves a message for her OB/GYN to also let the OB/GYN provider know the patient's distress after the miscarriage. He wonders if her presentation could be related to any hormonal dysregulation and the withdrawal of IVF medications.

The PCP also wonders if the patient is acutely depressed, acutely grieving, or having some somatic symptoms as a result of the recent loss and difficulties with her husband. The PCP works to find a culturally sensitive way to discuss the patient's mental health issues with the patient. He frames the patient's difficulties as the result of the recent loss that can impact both the body and the mind, leading to her physical and psychological symptoms.

The patient is facing various cultural stressors exacerbating her stress and grief, and the PCP tries to engage thoughtfully in a discussion with her before determining a course of action. The internist hears how judged the patient feels by her husband and her mother, and does not involve the patient's husband and mother at this time, as the patient could feel more ashamed or judged. The patient expresses feeling blamed by her husband and particularly her mother, who implied that she is weak for being so sad about the miscarriage. The patient also feels upset with her mother for linking the miscarriage to her karma.

In the end, the internist discusses options for treatment with the patient, who declines medications at this time but does agree to go to the emergency room to get help from a counseling referral. She feels strongly against psychiatric medications as she believes her family would judge her for needing medications for sleep or for her sadness but does want to speak to someone who can understand her feelings about the miscarriage as well as her difficulties with her husband.

The PCP negotiates with the patient to go to the emergency room to help her find a referral and also ensure her safety and privacy in discussing her difficulties more in depth. The patient agrees to go to the emergency room and speaks with a social worker who gives her a referral list for therapists specializing in women's issues in addition to information for a South Asian domestic violence organization, with the hopes that the patient might be able to find a therapist knowledgeable about South Asian culture through this resource. The patient declines a referral for a group for women who have faced recent miscarriages, though does feel helped to hear the social worker normalize her feelings of grief and loss about the miscarriage.

Case 3

A 19-year-old Chinese American woman freshman in college presents to her college mental health center with her roommates during the winter session. The patient has never been in mental health treatment before, but her roommates are concerned about her, as she has not been sleeping and has been behaving erratically and not like herself: speaking rapidly, staying out late at night, and drinking on weeknights. The roommates have thought about calling her parents, but they are hesitant, because the patient has stated that her parents are very strict Christians. Her parents have wanted her to come home on the weekends as they live within a 2-hour drive from the college. The parents want her to tutor her younger sister in high school and spend time with her grandmother who lives with the family. The patient has not been returning phone calls to the family and has not been returning their text messages. During the first month of the semester, the patient visited home for two weekends, and her parents and sister visited the two other weekends.

The counselor available for walk-in appointments at the health center obtained this history from the roommates and speaks to the patient, who exhibits pressured speech. The patient is annoyed at her roommates for bringing her in to the counseling center but is willing to talk to the counselor.

Discussion

The counselor is unclear about what is happening with this patient and has a broad differential diagnosis that includes bipolar disorder, major depression, a medical problem, an anxiety disorder, a substance use disorder, and/or a separation/individuation family-related difficulty. The counselor first asks about the adjustment to college this semester; the patient describes feeling a sense of freedom from her family after the first month when she decided to stop going home as frequently. The patient reports having a very strict curfew at home and not being allowed to spend much time with friends outside of high school and church. Of note, the counselor is from an African-American evangelical Christian background and feels a sense of identification with the patient, which she notes. While the therapist feels that separation/individuation conflicts may not be as pronounced in her own background, she can appreciate that the patient is caught between a sense of duty and obligation to her parents, sister, and grandmother and also wanting to explore life in college.

The patient discloses that she has been enjoying staying out late on Saturday nights and sleeping in very late on Sunday mornings. The therapist gets the sense that for the patient, expressing her own desires and having autonomy may be particularly important given her cultural and religious strict upbringing. She feels that on some level the patient may be testing out her autonomy and may need to close off communication with her family in order to do so. The therapist tries to validate the patient's choices to experiment but also asks the patient to think about why her roommates may be concerned about the changes in her behavior. The patient, feeling not judged or criticized by the therapist, admits that she has been experimenting with drinking and using cocaine when she goes out to parties. While she has been enjoying herself, she has been more lax about her responsibilities, such as going to class. The patient describes having grown up with a sense of needing to be a "model minority." In talking more with the patient, the counselor feels less concerned about the patient having an acute manic episode but does recommend to the patient short-term therapy to explore her feelings around leaving home and being in a less-restrictive environment.

Conclusions and Future Directions

The population of Asian Americans in the United States is rapidly growing, and their mental health needs are mounting as well. These needs in Asian Americans will reach a crisis point if the mental health field does not grow in its understanding of this population. Asian Americans continue to underutilize mental health-care services, though the reasons for this could be further elucidated, despite the increase of research and efforts devoted to this population by clinicians, researchers, and educators.

This chapter has highlighted that there is a lack of reliable data of the incidence and prevalence of mental health disorders in Asian Americans. This missing information makes the task of developing targeted interventions to decrease stigma and shame and increase awareness of mental conditions quite difficult. A realistic appraisal of the mental health diagnoses and impact of mental health disorders on Asian American populations is a critical future direction for researchers. Additionally, it is essential to assess the prevalence and incidence of different diagnoses in ethnic subgroups, as the population of Asian Americans expands and further diversifies.

Other significant areas of further study are the utilization of interpreter services, ethnic and language concordant mental health services targeted to Asian American populations, and the impacts of racism, discrimination against LGBTQ populations, and other traumas on mental health. The current medical literature has a stunning lack of research in these areas that would strongly impact the design of mental health services and interventions. Cultural idioms of distress continue to challenge mental health clinicians and researchers with their potential overlap with DSM and ICD diagnoses in this population and populations worldwide. It is not clear that these conditions will continue to be considered as "culture bound" as the pace of globalization continues.

Asian Americans are clearly not a "model minority" when it comes to mental health, and it is imperative that mental health clinicians, researchers, and educators work to further characterize, understand, and meet their needs.

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11

Cultural Sensitivity: What Should We Understand About Latinos?

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Introduction

The Latino population is increasing at a rate far surpassing the capacity needed to understand and respond to their mental health needs. Latinos make up the fastest-growing population segment of the USA, making up 17.6% of the total US population in 2015, from 3.5% in 1960 [1]. The Hispanic/Latino community is expected to reach 28.6% (119 million) of the United States (US) population by 2060 [2] making it the nation's largest and youngest racial and ethnic group. This dramatic demographic shift raises questions about the ability of mental healthcare systems to address the needs of this rapidly growing and diverse population. Interestingly, since the year 2000, there has been a shift in terms of the primary source of Latino population growth moving from immigration to Latino births in the USA [3]. In this chapter, we will use "Latino" and "Hispanic" interchangeably, but it is important to know that "Hispanic" refers to a common language (describing those whose ancestry comes from Spain or Spanish-speaking countries), while "Latino" refers to geography, specifically to individuals with Latin America origin. In the year 2000, foreign-born Latinos comprised 40% of the total Latino population in the USA, while in 2015, the share of foreign-born Latinos declined to 34.4%; alternatively, the share of US-born Latinos went from 59.9% in 2000 to 65.6% in 2015 [4]. These opposing trends have begun to reshape the adult Hispanic population with obvious consequences on how healthcare providers understand and deliver care. As mental health providers, we have a duty to actualize our cultural understanding of this diverse group, providing care based on a model of cultural humility, tailored to each generation of Latinos living in the USA.

Latinos face inequities in terms of education, socioeconomic status, and access to care, and

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such inequities are often exacerbated by language barriers. The differences are so striking that in their report, the Institute of Medicine states that Hispanic Americans “face greater barriers than any other racial and ethnic group in the U.S.” [5]. Despite the enormous toll that mental health problems exact upon the well-being of children, adults, and families, disparities in access to and adequacy of quality mental health services exist for Latinos [6], who are more likely to receive less and inferior mental health services as compared to non-Latino Whites [7]. A growing demand coupled with a high level of unmet needs represents a significant challenge in addressing the mental health needs of this population [7–9].

Latino youth make fewer office visits for ADHD and depression [10, 11] than non-Latino White children and are also less likely to be identified as having a need for behavioral services when compared to Caucasian and African American children [12]. Latino adolescents report lower average scores on antidepressant and counseling knowledge than White teens [13] and lower rates of mental health service use [14] and are less likely to report receiving assistance when they endorse suicidal ideation [15]. Since knowledge about medications and counseling is associated with willingness to seek active treatment in adolescents, it is not hard to see how structural barriers to accessing mental healthcare among Latino youth (i.e., difficulties related to health insurance coverage and high cost of mental health services, low wages among Latino parents), coupled with scarce community-based psychoeducation and cultural stigma associated with mental health, would lead to problems accessing mental healthcare among Latino youth.

Adult Latinos are more likely than their non-Latino White counterparts to be under- or uninsured [15, 16], and to be poorer [1, 17], are more likely to confront language and cultural barriers [18], and are less likely to have access to existing mental health services [19–21], Early release data estimates based on data from the 2016 National Health Interview Survey (NHIS) [16] continue to show these disparities after adjusting for age and sex; Latinos continue to be less likely to have a usual place to go for medical care compared with both non-Latino White and non-Latino Black counterparts. Even when they access treatment, Latinos are also less likely to remain in treatment [22] or endorse not having received good quality care [23]. In addition, although Latinos tend to present with more severe alcohol use-related problems than non-Latino Whites, they are less likely to receive specialty care and report more barriers to obtaining care as compared to non-Latino Whites. Furthermore, there is evidence showing that Latino men have greater odds of dependence even at the lowest and moderate levels of heavy drinking relative to non-Latino White men and that among low-level heavy drinkers, Latino men had twice as high rates of work/legal consequences when compared to non-Latino White men [24]. Yet, a dearth of research examining underlying mechanisms leading to differences in pathogenesis and illness severity among Latinos and few evidence-based initiatives aimed to address the systemic problems Latinos encounter in already existing mental health services.

The purpose of this chapter is to provide mental health professionals with an overview of the existing literature on various cultural aspects of Latinos living in the USA so that they may be able to integrate cultural humility and sensitivity in their work with this population. This chapter reviews the literature on the prevalence of mental health and substance use disorders (SUDs) in Latinos, disparities that exist in mental health and education among Latinos, and other mental health factors pertinent to this diverse population. Our goal is to provide mental health professionals with a more nuanced sense of this heterogeneous group and the challenges Latinos face so that a respectful interaction that takes into account their cultural beliefs and preferences for treatment is fostered. A narrative therapy model will be used throughout this chapter when offering suggestions and recommendations for mental health professionals. This model will be discussed in detail later.

Assessing Diversity Among Latinos

The US Latino population is quite heterogeneous in its composition. Latinos living in the USA come from many parts of the world, including South America, Central America, the Caribbean, and North America. Mental health professionals need to understand culturally mediated factors relevant to their patient's experience, including discrete patterns of migration, reception in the USA, acculturation experiences, demographic patterns, and living circumstances [19, 25, 26]. Mexico is the largest birth country among the US foreign-born population; 63.3% of Latinos in the USA are Mexicans, while Puerto Ricans, the second largest foreign-born Latino group in the USA, represent only 9.5% of Latino population in the USA [1]. For example, Puerto Ricans traditionally were more likely to reside in the Northeast as compared to the other Latino subgroups, but recent data shows that between 2005 and 2016, Florida's share of the total inflow from Puerto Rico to the USA has far exceeded that of any other state [27]. Although New York still has the largest population of Puerto Ricans on the mainland, given increase inflow of Puerto Ricans to states like Florida and Texas coupled with a decrease inflow of Puerto Ricans to New York (31% Puerto Ricans lived in New York in 2000 compared to 20% in 2016), estimates have predicted that new surveys gathered in 2017 might well show that Florida has become the state with the largest Puerto Rican population in the mainland [27]. Mexicans are more likely to be younger (18–34 years), live in the West (51%), and have lower levels of education than other Latinos in the USA and the US population overall [28]. In contrast, Cubans are older (≥65 years) with almost half of immigrants from Cuba having been in the USA for over 20 years; Cubans also have higher levels of education with one quarter of Cubans ≥25 years having obtained at least a bachelor's degree as compared to 14% of other foreign-born Latinos living in the USA [29]. Although the term *Latino* has been used interchangeably with the term *Hispanic*, the creation of these labels has different historical origins. The term "Hispanic" was created by the US Census to refer to people of Spanish origin living in the USA [30]. In contrast, the term Latino emerged from community-based initiatives. The term Latino is thought to affirm native, pre-Hispanic identity and is preferred by some Hispanics/Latinos/as since it is thought to convey a sense of belonging to a diverse group of people who speak one or more of the romance languages [31]. However, the Pew Research Center's 2013 National Survey of Latinos showed that half of Latinos say they have no preference for either term but when a preference is expressed, Hispanic (33%) is preferred over Latino (15%) by a margin of 2:1 [32].

The term Latino also represents complex and varied notions of race. According to Santiago-Rivera [33], most people in the Americas self-identify as *mestizo*, a blend of European and American Indian populations. Intermingling of Europeans, American Indians, and Africans results in mixed races and cultures, or what we refer to as multiracial groups. It is not easy to classify Latinos according to the categories provided by the US Census. In a 2011 national bilingual survey of 1220 Latino adults conducted by the Pew Hispanic Center [34], most Latinos responded that they preferred to use their family's country of origin (i.e., Puerto Ricans, Cubans, Mexicans) in describing their identity instead of pan-ethnic terms (the grouping together and collective labeling various self-sustained ethnicities into one all-encompassing group as Latinos) [34]. However, the terms used to describe identity seem to be linked to immigrant generation. Among foreign-born Latinos, 66% say they describe themselves most often by their country of origin term (i.e., Mexican, Colombian, Dominican), 48% of second-generation Latinos say the same, while only 20% of third-generation Latinos would describe themselves by their family's country of origin. Therefore, in accordance with a narrative perspective of identity construction and a "willingness to learn from [the] patient" (although some of the literature uses the term client instead of patient, in this chapter we will use patient), it is important that one ask patients how they self-identify and to let them choose accordingly in order to promote the development of a therapeutic alliance.

Providers also need to be cognizant of the effect that providers' implicit attitudes can have on the quality of clinical care delivered to minority patients. Targeting efforts toward increasing clinician's self-awareness of implicit attitudes, as well as decreasing provider's stigmatization and Latino homogenization, are necessary if we want to eliminate disparities in healthcare and provide clinical care stemming from a model of cultural humility.

Complex Dynamics That Place Latinos at Risk for Mental Illness

There are many risk factors for mental illness that disproportionately impact Latinos in the USA, including poverty, food insecurity, lack of insurance, community trauma, and/or exposure to violence [35]. Almost 20% of Latinos live below the poverty level as compared to almost 9% of non-Latino Whites. Among Latino children and adolescents, 28% live in poverty, more than double the rates of non-Latino Whites (12%) [36]. Poverty is associated with significant psychosocial and health vulnerabilities [25]. Food insecurity, also high among those with low socioeconomic status (SES), including Latino children [25, 37], is associated with a heightened risk of past-year mood, anxiety, behavior, and SUDs [37, 38].

Furthermore, many Latino children experience *compounded community trauma* or confronting and witnessing violence in both their homes and their neighborhoods [39], which is correlated with high rates of mental illness, including PTSD, depression, adoption of aggressive behaviors, and externalizing behaviors [40, 41]. Acculturation stressors such as discrimination and cultural conflicts, parental acculturative stress, and peer victimization have also been identified as potential contributors to Latino children's psychosocial maladjustment [42, 43]. There is also evidence that difficulties related to integration into US culture are stressful for both parents and youth and may increase the risk of psychopathology [44] among Latino youth. Moreover, Latino youth are more likely than non-Latino White youth to have interactions with the juvenile justice system [45] or to have relatives involved with the criminal justice system [46].

Racial/ethnic minority group consistently underutilize mental health services [47] even relative to psychiatric disorder, and differences in perceived need may contribute to these disparities [48]. Specifically, given the heterogeneity of Latino population, it is important to remember that each Latino subgroup might understand medical and psychiatric illnesses differently depending on the subgroups' place of origin, history, patterns, and effects of immigration [49]. In the case of Latino youth growing up as a minority in the USA, even the subgroups' conceptualization and identification might vary depending on which Latino subgroup their family identifies with. There is a considerable difference between presence of an underlying psychiatric disorder and the perception that one needs help among Hispanic adults relative to non-Hispanic Whites [50]. Latinos, especially those with low incomes, often interpret symptoms as normal responses to stressful life situations [51] and they tend to report somatic complaints in the face of psychiatric disorders [51] which may in turn delay or prevent realization of need for psychiatric services.

An interesting study published in 2018 by Villatoro et al. [48] analyzed a nationally representative sample of 14,906 non-Latino White, Asian American, Latino, African American, and Afro-Caribbean US adults (18 years or older), to examine whether differences in perceived need for mental health services across populations could be contributing to disparities in service utilization. They also assessed how the intersections of race/ethnicity, gender, and socioeconomic status affect perceived need. Researchers found that non-Latino White men were less likely to have perceived need for mental healthcare when compared to non-Latino White and Latinos irrespective of gender [48] concluding that social and economic disadvantage did not seem to be sufficient alone to account for patterns of perceived need. Instead, they recommend recognizing and adopting intersectional approaches to understanding perceived need since this may help uncover social processes that lead to disparities in mental healthcare [48].

National and school system-specific research suggests there may also be racial/ethnic disparities in the availability and utilization of special education, Title I (programs created by the program of education to improve the academic achievement of the disadvantaged), and remedial services that put Latino children at an academic disadvantage [52, 53]. Nevertheless, educational attainment has been used as a measure of an individual's or group's ability to succeed in the USA [26]. According to Ailinger et al. [54] education can empower individuals and may buffer against distress and mental illness by enhancing social status and access to resources. According to data from US Census Bureau, Latino high school dropout rate has been declining consistently going from 34% in 1996 to a record 10% in 2016 [55] but is still double the rate of non-Latino White adolescent dropout (5%). Latino college enrollment rates have also been on the rise going from 35% in 1996 to 47% in 2016 and have reached rates of non-Latino Whites but still below Asian rates that remain at 62%. Although Latinos have made important progress over the last two decades, only 16.4% obtain a bachelor's degree or higher compared to 37.3% of non-Latino Whites, 55.9% of Asians, or 23.3% of African Americans [56]. Low educational attainment among Latinos is associated with many other factors, including financial stress, acculturative stress, and discrimination [57, 58]. Another factor deemed instrumental to low educational attainment among many Latinos is the necessity of leaving school to obtain work that can financially support their families [59]. The absence of Latinos in leadership positions creates a self-perpetuating cycle: fewer Latinos serve as role models, and fewer young Latino scholars aspire to obtain postsecondary education [60].

Another complicated problem that affects minorities' access and/or continuation of healthcare services is stigma and stereotypization, often causing distrust toward healthcare systems and individual providers. Stereotypes not only affect providers' delivery of healthcare and academic performance, they can also impact self-image, social development, and overall well-being, especially among Latino youth [49]. Stereotype threat studies have shown that this extra pressure can undermine the targeted groups' (immigrants, minorities) academic performance [61] and, especially among youth from minority groups, even lead to behaviors that directly undermine health, such as adoption of unhealthy eating behaviors and subsequent weight gain [62]. Providers must examine their own cognitive and affective processes during medical decision-making, since "implicit social attitudes and stereotypes stored in memory may be retrieved automatically without awareness, unintentionally influencing medical care" [5]. In this time of massive advances around media, technology, and telecommunication, mental health providers and systems should take advantage of technology and utilize media platforms to raise mental health awareness among Latinos. Messages targeted specifically to Latino communities providing bicultural and bilingual resources around mental health-based interventions can help reduce stigma associated with mental health disorders and increase access to care among Latinos.

Although the fact that one in four Latinos speaks only English at home [63], language-based limitations may serve to constrain Latinos' engagement with institutional supports such as schools and/or medical care. Limited English proficiency has been linked to poor access to and treatment of mental health disorders [64]. According to Knight et al. [65], a substantial proportion of Latinos are either not fluent in English or feel more comfortable speaking in Spanish: 30% of Latinos report difficulty in communicating with their healthcare providers [66]. According to Pippins et al. [64], insured Latinos with poor/fair English language proficiency are more likely than those with good/excellent proficiency to report not having a regular source of care or lacking continuity of care. According to the *AMA Journal of Ethics* [67] "patients with limited English proficiency (LEP) are among the most vulnerable populations." Patients with LEP consistently receive lower-quality care than English-proficient patients: they have more difficulties understanding treatment plans and disease processes and experience higher rates of medical errors resulting in physical harm [68]. Adult patients and/or parents of child patients who have limited English proficiency (LEP) report that the absence of Spanish-speaking staff members is responsible for their poor medical care, including misdiagnosis, inappropriate medications, and unnecessary hospitalizations [69]. LEP parents are more likely to report poor communication with healthcare providers than English-proficient parents [70, 71]. LEP can also impact the delivery of educational services among racial/ethnic minority families [72]. Evidence suggests that limited English fluency is associated with parental avoidance of school meetings [73] and/or written communication from school. Teachers and school staff can sometimes misinterpret the lack of parental involvement in the school system or academic performance of Latino children as them not being interested or supportive of their children's academic achievements. However, it is rare that lack of parents' involvement is in fact stemming from an uncaring or unsupportive parent but, more often than not, related to other sociocultural aspects affecting how Latino parents view their role within the school system. In fact, factors such as parent's unfamiliarity with the system, language barrier, and even Latino's cultural value of respect and deference toward authority figures have been attributed to lack of parental involvement [74]. Ceballo et al. [74] evaluated the relationship between parental involvement in low-income Latino families and academic outcomes and found that adolescents that had heard parental stories describing their own struggles with poverty and immigration had an increased desire to succeed academically and give back to their parents. Therefore, if we recognize that an increase in Latinos' parental involvement within the school system can incentivize and promote children's interest and efforts to succeed academically, we need to ensure that the next generation of educators promotes an environment of support, collaboration, and multiculturalism within the school system.

Latinos and other minority populations are more likely to reside in structurally and economically deprived neighborhoods [75, 76]. These social and contextual factors influence and/or determine the life circumstances of Latinos and place them at risk for poor health outcomes and healthcare services. Myers [77] argues that socioeconomic status (SES) is the most important factor underlying racial and ethnic disparities in health because it leads to differences in material and psychological resources, environmental and behavioral risks, and differences in access to healthcare. However, Myers also recognizes that disparities are the result of a complex interaction of factors that include poverty and minority status [77]. Therefore, an intersectional approach considers the interaction between SES and the social and contextual factors that specifically influence and/or determine the life circumstances of Latinos, helping providers understand and more effectively recognize the elevated risk for poor health outcomes and healthcare services among Latinos.

Prevalence of Mental Health and SUDs in Latinos

Eight population-based epidemiological studies conducted in the USA and Puerto Rico from 1983 to 2003 have examined the prevalence of psychiatric disorders among adult Latinos. These studies include the Los Angeles Epidemiologic Catchment Area Study (LA-ECA), the Puerto Rico Epidemiologic Catchment Area Study (PR-ECA), the Hispanic Health and Nutrition Examination Survey (HHANES), the Mexican American Prevalence and Services Survey (MAPSS), the National Comorbidity Study (NCS), the National Comorbidity Survey-Replication (NCS-R), the National Epidemiological Survey on Alcohol and Related Conditions (NESARC), and the National Latino and Asian American Study (NLAAS). Please consult Canino and Alegría [43] for a thorough review of these studies. What follows is a brief review of the important findings of these studies. There are significant differences in the prevalence of mental health and SUDs among adult Latinos as compared to non-Latino Whites. After adjusting for sociodemographic factors, evidence from most research suggests that Latinos in the USA seem to be at lower risk for most psychiatric disorders as compared to non-Latino Whites [78]. For any lifetime disorder, 29.7% of adult Latinos meet criteria as compared to 43.2% of non-Latino Whites [78]. Lifetime prevalence rates for any SUD are reported to be 11.2% and 17.7% for Latinos and non-Latino Whites, respectively. However, when Latinos are stratified by nativity (foreign-born or US-born Latino), US-born Latinos are at significantly *higher* risk for all lifetime disorders (37.3%) [78] as compared to their foreign-born counterparts (23.5%). This has been labeled the *immigrant paradox*. This means that Latino immigrants have better overall mental health than both their US-born Latino counterparts and non-Latino Whites [79–82]. Despite acculturative stress, poverty, discrimination, and other risks associated with the development of mental health disorders, foreign nativity seems protective against psychiatric illness. Alegría and Woo [21] found that when Latinos are disaggregated by ethnicity, the immigrant paradox is observed only among specific ethnic groups, with specific disorders. For example, Mexicans retain protective factors associated with foreign-born nativity for depression, anxiety, and SUDs, while Puerto Ricans do not. Furthermore, US mainland-born Puerto Rican females report higher rates of generalized anxiety disorder (GAD) (11.6%) than other US-born female Latina groups. Puerto Rican female migrants also have higher rates of PTSD (9.0%) than any other immigrant Latina groups as well.

The Hispanic Community Health Study of Latinos (HCHS)/Study of Latinos (SOL) or HCHS/SOL [83] is a multicenter, community-based cohort study of 16,000 Hispanic/Latinos in the USA aged 18–64 years interviewed between 2008 and 2011; the majority of the participants had migrated to the USA in adulthood at age 20 or older. The objective of this study was to collect information on the health status and disease burden of Latinos living in the USA and to identify protective or risk factors playing a role in the health of Latinos. Using data from this study, Perreira et al. [84] performed logistic regressions to model the risk of moderate to severe symptoms of psychological distress, depression, and anxiety as a function of years in the USA. Perreira et al. findings were consistent with findings from NLAAS; higher rates of moderate to severe symptoms of psychological distress, depression, and anxiety were associated with participants' longer exposure to the USA; however, this association varied by Latino background. For example, foreign-born Puerto Ricans had the highest rates of moderate to severe symptoms of psychological distress, depression, and anxiety, but after adjusting for factors such as perceived discrimination, perceived US social standing, and size of close social networks, there were no significant associations between years in the USA and depression for Puerto Ricans. There was also a significant positive association between years in the USA and anxiety among foreign-born Dominicans. On the contrary, Central Americans (i.e., Guatemala, El Salvador) appeared to have improvement in their mental health (i.e., lower risk of depression and anxiety symptoms) the longer they lived in the USA [84]. Authors hypothesized that some Central Americans might have a different experience compared to other Latino immigrants, after receiving asylee/refugee status in context of emigrating from countries torn by war and natural disasters, which could in turn improve their experience in the USA and subsequently improve their mental health with years spent in the USA. Consistent with findings listed above, Perreira et al. found that US mainland-born Puerto Ricans had higher rates of moderate to severe symptoms of psychological distress, depressive symptoms, and anxiety when compared to other US-born Latinos. These results clearly demonstrate that the relationship between exposure to the USA and mental health varies by Hispanic/Latino background. Despite dramatic differences in Latinos' economic and social circumstances (i.e., education and citizenship), epidemiologic data evidences similarities in lifetime psychiatric prevalence estimates across

Cubans, Mexicans, and other Latinos (i.e., South Americans). However, these averages mask some differences across sub-ethnicity by nativity and gender. Indeed, mental health professionals should be cautious when working with this diverse population and avoid generalizations [21, 85] that do not take into account immigration status, gender, and age differences.

Among youth (ages 13–17), data from the National Comorbidity Survey Replication Adolescent Supplement (NCS-A) [86] showed that Latino youth were less likely than non-Hispanic White youth to receive services for severe ADHD. Results from NCS-A also showed that despite having higher rates of mood and anxiety disorders, Latino adolescents were less likely to receive treatment compared to White children. Unfortunately, recent data [87] continues to sustain previous research showing that White youth aged 5–21 is still more likely to initiate treatment for almost all mental health conditions compared to Latino youth. The NCS-A used a measure of aggregated disorder severity that represented the highest severity level within the disorder type (i.e., externalizing, internalizing), using a count of lifetime symptoms and questions about functional impairment.

Evidence from the NCS-A and multiple subsequent studies suggest that the immigrant paradox exists for Latino youth. Immigrant Latino youth, for example, are less likely to engage in risky sexual behavior and substance use than their US-born Latino peers [88]. Maintaining cultural ties with traditional values may be protective for Latino youth, underscoring the importance of embracing and promoting multiculturalism among adolescents from minority groups while helping parents recognize differences in levels of acculturation even among members of the same family.

The Youth Risk Behavior Surveillance System (YRBS) was developed by the CDC in 1990 to monitor health behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the USA [89]. This national survey, conducted every 2 years, provides data representative of ninth through 12th grade students in public and private schools in the USA. Most recent data from the 2017 YRBS showed that in the last 10 years, less Latino youngsters have experienced persistent feelings of sadness or hopelessness, 33.7% in 2017 compared to 36% in 2007. However, Latino youth continue to be the group with the highest percentage of youngsters experiencing persistent sadness/hopelessness compared to 30.2% non-Latino White and 29.3% of Black students [90]. Furthermore, the percentage of Latino students who seriously considered attempting suicide increased significantly from 2007 (15.9%) through 2017 (16.4%), as did the number of Latino youngsters who made a suicide plan (12.8% in 2007 to 13.5% in 2017). And even though Latino students continue to have a higher rate of suicide attempts compared to non-Latino White students (8.2% vs. 6.1%), there was no significant change in suicide attempt rates compared to 2007 rates [90]. This data shows that even though mental health systems targeting youth in the USA have been put in place for over a decade, Latino students continue to be the group that struggles the most. These concerning rates demonstrate the need for mental health-based interventions specifically directed toward Latino youth focused on both US-born and non-US-born Latinos but keeping in mind the immigrant paradox and how this might affect different Latino youth subgroups.

Biomedical Considerations

Selected Genetic and Environmental Studies in Hispanics

Genetics have been noted to play an important role in the transmission and phenotypic expression of several psychiatric disorders (including attention deficit hyperactivity disorder, bipolar affective disorder, Alzheimer's disease, schizophrenia, and alcohol abuse), though they may vary among specific ethnic groups within Latinos [91, 92]. For schizophrenia, the contribution of genetic factors in the general population has been estimated to be between 60% and 85% and genes 6p22–p24, 1q21–q22, 13p32–p34, and 22q11–q12 have been the most frequently implicated [93]. In a study conducted by Escamilla et al. [92] among families with a diagnosis of schizophrenia, schizoaffective disorder, and/or other psychotic disorders, gene 17q21 was found to contribute to its development in adults from Central America even though it is not associated with schizophrenia in the general population.

Several studies have reported an association between the apolipoprotein E-e4 genotype (APOE-e4) and Alzheimer's disease (AD). Per Blennow et al. [94] this genotype is associated with a threefold risk increase of developing AD in heterozygote carriers and a 15-fold risk increase in homozygote carriers. Similarly, a study in Texas showed that Mexicans had a lower age on onset and more depressive symptoms than non-Latino Whites [95]. Livney et al. [96] found that Latinos (87% of cohort were Puerto Rican) had an earlier age onset of AD, exhibited more cognitive impairment, and experienced greater severity of symptoms than African Americans and non-Hispanic Whites. Interestingly, the Latino carriers of APOE-e4 did not develop AD earlier than the noncarriers, which contradicts the observation that African American and non-Hispanic White carriers typically develop the disease earlier in life [96]. It is now widely accepted that Latinos show an earlier age of onset of AD compared to White non-Hispanics [97] which cannot be fully explained by APOE-e4 carrier status. Even though Latinos tend to be clustered into one group, understanding the significant differences between subgroups might help differentiate the roles that genetic factors and other determinants of health play in the prevalence, severity of symptoms, and treatment of AD among Latinos.

Environmental factors can be important to promote or suppress gene expression [98]. A study conducted in the Southwestern USA, Mexico, and Central America by Jimenez-Castro et al. [99] found that Latinos with schizophrenia living in the USA were more likely to have a SUD than their Latino counterparts residing in Central America or Mexico. This suggests that environmental factors in the USA may increase the vulnerability of this population to substance disorders. Risk factors identified in this study included: male gender, residence in the USA, immigrant status from Mexico, history of a depressive disorder, and unemployment.

Psychotropic Considerations

All psychotropic medications require approval from the Federal Drug Administration (FDA) [100]. However, many have expressed the concern that minorities are underrepresented in research evidence presented to the FDA for approval. A review of drug applications submitted to the FDA between 2013 and 2015 noted underrepresentation of racial and ethnic minorities in the clinic trials [101]. This obviously raises concern because evidence shows that minorities, specifically Latinos, respond differently to certain medications, both in terms of effectiveness and tolerability. The same issue led to the 2012 FDA Safety and Innovation Act (FDASIA 907), through which US Congress required the FDA to report on the diversity of participants in clinical trials and the extent to which safety and effectiveness data is based on demographic factors such as sex, age, and race. In a double-blind randomized trial of Latino and non-Latino White patients with acute mania, Tamayo et al. [102] found that Latino patients responded equally as well to olanzapine (atypical antipsychotic) and haloperidol (typical antipsychotic), while non-Latino Whites reported a better response to olanzapine. The side effect profile of these medications also differed between both groups; Latinos experienced more weight gain and somnolence after taking both medications and reported more tremors with haloperidol than their non-Latino White counterparts. In addition, non-Latino Whites scored higher on the Barnes Akathisia Scale and Abnormal Involuntary Movement Scale [102] than did Latinos. Implications are that in Caucasians group you might want to favor olanzapine over haloperidol due to better response, but in Latinos preference might be focused on side effect profile and cost.

Evidence suggests that it is prudent to tailor treatment strategies to individual patients and to take the patient's ethnicity under consideration when developing a treatment plan involving the use of psychotropic medications.

Pharmacogenomics

Pharmacogenomics refers to the use of a patient's genetic profile to identify which medications have the highest probability of producing a desirable response with the fewest number of side effects [103]. One area of focus is the cytochrome P450 (CYP450) system, an enzymatic system in the liver responsible for the metabolism of various medications. Over 50 of these enzymes have been described in the literature. One of these enzymes, CYP2D6, is responsible for metabolizing many of the psychotropic agents, including haloperidol [104]. A variety of genetic polymorphisms found in humans affect the efficacy of these enzymes. Geneticists have categorized these polymorphisms according to their ability to metabolize drugs as poor metabolizers (PM), intermediate metabolizers (IM), extensive metabolizers (EM), or ultrarapid metabolizers (UM). Many studies have shown that individuals with the CYP-2D6 poor metabolizer (PM) polymorphism are at an increased risk of having higher blood serum haloperidol levels with an associated increased incidence of side effects [104]. The frequency of these polymorphisms varies among ethnic groups. For example, approximately 10% of Caucasians and Hispanics are poor metabolizers, while only 2–4% of African Americans and 1–2% of Asians are poor metabolizers. As such, pharmacogenomics may offer another way of tailoring efficacious treatment to individuals. Clinicians should be aware that treatment response is influenced by a myriad of factors, in which family history of antidepressant response has been found to be an important and useful one [105], therefore highlighting the importance of "old tech" good history taking. In addition, the availability of pharmacogenetic support tool like GeneSight, CNSDose, IDgenetix, and Genecept, among others, can provide aid in complicated or nonresponsive patients and can provide information on who might be at higher risk of certain side effect profile; nevertheless, they are still not recommended for routine clinical use [106].

Psychopharmacological Adherence

One of the most frequent causes of treatment failure is psychopharmacological nonadherence. In a literature review of 21 studies that included Latino populations, Lanouette et al. [107] found that the rate of nonadherence to psychotropic medication was 44% among studies that include only Latinos and 40% in studies that included multiple ethnic groups. In contrast, the nonadherence rate for non-Latino Whites was 30%. This represents an effect size difference of 0.64, suggesting a medium to large difference between the Latino and non-Latino Whites in medication nonadherence. Risk factors for nonadherence in these studies included substance abuse, barriers to access of high-quality healthcare, lack of health insurance, and limited family support [107]. Protective factors associated with better adherence were higher SES, older age, greater family instrumental and financial support, being married, having public or private insurance, being proactive in one's care, and having made at least eight visits to a therapist. An important finding in this review was that nonadherence to treatment predicted worse outcomes.

In a qualitative study of Latino immigrants, patient compliance with antidepressant treatment was positively influenced by having a good relationship with medical providers, having previous experience with depression and its treatment, receiving family support, holding positive expectations of treatment effectiveness, and having cultural values that promoted adherence such as "*luchar*" (persevering despite difficulty), "*poner de su parte*" (do one's part), and religious faith [108]. Furthermore, one third of Latinos have been shown to discontinue taking antidepressants, and 18.9% did so without input from their physicians [109]. Saloner and Cook

[110] found that Blacks and Hispanics were less likely than Whites to complete publicly funded substance abuse treatment. This was explained by differences in SES, unemployment, and housing instability. Finally, Kopelowicz et al. [111] found that educating all family members on medication compliance significantly enhanced treatment outcomes and accounted for one third of the reduced risk for inpatient psychiatric hospitalization. Interestingly, a study among Latinos with a diagnosis of schizophrenia found that a greater proportion of Latinos with LEP were adherent to antipsychotics compared to English-proficient Latinos with schizophrenia [112].

Mental Health Disparities

Even though Latinos are the largest ethnic minority group in the USA, their mental health needs and service utilization patterns do not reflect their size. Latinos have less access to mental healthcare and are less likely to receive mental health services than non-Latino Whites [20, 21]. According to the 2011/2012 National Survey of Children's Health [21], only 53.8% of Latino children (ages 2–17 years old) needed and received mental health services/counseling in the past 12 months, compared to 68% of White children who needed and received mental health services/counseling in the last year. Conversely, 46% of Latino youth needed but did not receive mental health services/counseling within the past 12 months, versus 31.9% of White youth who did not receive care despite requiring it during the same period.

The National Healthcare Disparities Report [6] showed that Latinos are less likely to have received needed care for substance abuse treatment than their White counterparts [113]. Furthermore, Vega and Alegría [114] note that Latinos are more likely to receive services that fail to meet their needs. Potential explanations for these disparities and for mental health problems among this population include discrimination, acculturative stress, poor language proficiency, low SES, lower educational level, lack of insurance, institutional barriers, and a lack of skilled providers who are culturally sensitive [20, 21, 26, 65, 115, 116]. Many scholars have also attributed mental health service disparities to discrimination [117–119], while lack of insurance has been associated with poor access to care. Per data from the 2015 American Community Survey [1], uninsured rate for Latinos was almost 20% (19.7%), which is more than double the national uninsured rate average (9.7%). There are studies showing that Latinos have a record of receiving insufficient quantity and quality of care even when insurance availability is not a factor [113]. Not only do Latinos report low levels of access to care; they also have high rates of dropout and missed appointments and poor medication adherence [120]. This has been attributed to linguistic incompatibility between clinicians and patients [66] as well as to a dearth of available treatments and personnel who can provide culturally sensitive care. Vega et al. [121] have stressed the importance of considering the role of language in the acculturation process, the patient's symptom presentation, and the level of patient disclosure to their therapist. Per Vega et al. [121] problems in detection and diagnosis due to language barriers can result in less effective and more costly treatment, clinical error, frustration of patients, and greater burden on caregivers [122]. Another important impediment for Latinos to access mental health services, especially when it comes to seeking mental healthcare for their children, is the fear that immigrant parents experience around their legal status and the possibility of their children being taken away from them.

Language plays an important role in obtaining informed consent from a patient. Language barriers, unfortunately, prevent Spanish-speaking Latinos from accurately understanding written information that is part of an informed consent. An important task in the evaluation of any patient is assessing his or her capacity to understand and make a volitional choice. There are four criteria that a provider should consider when evaluating a patient's decision-making capacity: (1) the patient's ability to understand the information about his/her treatment, (2) the patient's ability to grasp what the information means and how it relates to his/her diagnosis and available treatment options, (3) the patient's ability to understand the treatment options, and (4) the patient's ability to communicate his or her decision consistently [123]. For a patient to make an informed decision regarding his/her treatment, it is important that he/she fully understand the information transmitted [124]. If the patient has difficulty understanding the language in which the information is transmitted, he or she might not be able to fully comply with the requirements needed to make an informed decision. As previously mentioned, a substantial proportion of Latinos are either not fluent in English or feel much more comfortable speaking in Spanish. If patients cannot communicate their health problems in an accurate way, providers may make erroneous diagnoses and/or treatment decisions [23]. A study conducted by Baker et al. [125] involving 467 native Spanish-speaking and 63 English-speaking Latino patients in a public hospital emergency room setting found that patients who did not speak the same language as their providers had poorer treatment adherence as compared to those patients who spoke their provider's same language. To decrease the language barriers, present between patients and providers, some researchers have suggested using professional medical translators [126, 127]. Per a study conducted by Ginde et al. [126], although 11% of patients treated in an Emergency Department (ED) required an interpreter, only 4% received the service. Among those Spanish speakers who had interpreters, it was found that they had higher rates of primary care follow-ups and lower rates of return to the ED in the next 30 days. As such, it is recommended that providers who have limited knowledge or do not speak the patient's language use trained medical interpreters to deliver effective treatment. Furthermore, it is not recommended that providers use family members, especially children, as interpreters, as this has been associated with a disruption of the family hierarchical balance [26].

In addition, Latino gender roles have traditionally associated Latino women with help-seeking behaviors. Studies have consistently shown that Latino women use more health and mental health services than men [128, 129]. The low utilization of mental health services and low treatment adherence by Latino men has been associated with their traditional perception of masculinity, or *machismo* [130]. Males who seek mental health services are often interpreted as being weak and unable to protect their families. To reduce such barriers to accessing care, therapists should explore the barriers placed by traditional gender roles, particularly among their male patients. The narrative of strength and protectiveness of the family should be included in the positive reframing of seeking treatment. For example, when a male Latino patient expresses his reluctance to receive help and instead solve his family's problems on his own, a culturally sensitive therapist could emphasize his/her patient's need to protect his family by the patient getting involved and involving his family in the treatment process. The clinician can reframe the male's involvement in treatment as a sign of both strength and courage.

Ethnic Matching

Ethnic matching refers to the matching between patients and clinicians in psychotherapy by their ethnicity. Ethnic matching has had mixed results and appears to be a complex, multifaceted issue [131]. However, ethnic matching has been associated with increased use of community mental health services and a reduction of emergency services. In a study conducted in Australia by Zyguras et al. [132], the investigators found that when patients of an ethnic minority were matched with clinicians from the same ethnic background, these patients had better outcomes. The patients who were ethnically matched with providers were noted to have longer retention in care [133] and greater frequency of contact with community care teams. In addition, contact with crisis teams occurred less often and lasted less time with patients who were ethnically matched. Furthermore, ethnic matching has also been linked to achieving culturally sensitive treatments [134, 135].

However, there are important limitations to ethnic matching among Latinos. Despite research suggesting the importance of ethnic matching and culturally adapted treatments which take language into consideration, Bernal et al. [136] pointed out the shortage of Latino mental health professionals in the USA, highlighting the lack of interventions developed for Spanish speakers. Second, there is a shortage of Latino mental health professionals in the USA [33, 137].

On the other hand, a meta-analysis conducted by Cabral and Smith [138] with Latino patients and patients of other ethnic minority groups found that ethnic matching yielded mixed results. These authors assessed three variables related to racial/ethnic matching including: (1) the patient's preference for a therapist of his/her own race/ethnicity, (2) the patient's perception of his/her therapist across racial/ethnic match, and (3) therapeutic outcomes across racial/ethnic match. The investigators of this study found a moderate effect size for the first two variables, indicating that patients tend to prefer and perceive a therapist of their own race/ethnicity more positively than therapists of other races/ethnicities. In terms of assessing therapeutic outcomes, however, racial/ethnic matching did not reveal any benefit, except for African Americans, who benefited in all three areas. More specifically, African Americans preferred to be matched with African American therapists, they evaluated their therapist more positively when they were matched, and they seemed to achieve better outcomes when matched by race. Interestingly, even though Latino patients express the preference that their therapist be their same ethnicity, there was no significant difference in terms of their perception of the therapist or on clinical outcome whether they were matched. Cabral and Smith [138] conclude that patients might prefer a therapist of their own race/ethnicity because of the belief that their therapist might share their same worldview; however, once they start treatment, ethnic matching does not affect their evaluation of the therapist and to their overall clinical outcomes. In sum, Cabral and Smith [138] encourage therapist alignment with the patient's worldview instead of focusing on ethnic matching. The collective experience of these authors encourages both therapist alignment with the patient's worldview and culturally adapted treatments which take language into consideration.

Narrative Therapy

A narrative framework has been used throughout this chapter when offering suggestions and recommendations for mental health providers. Narrative therapy was developed by Michael White and David Epston in the 1980s and emphasizes the importance of the use of language in shaping people's realities [139]. This narrative framework is based on Michel Foucault's philosophy that dominant discourses of society which objectify and dehumanize individuals belonging to marginalized or oppressed groups ultimately become internalized truths for the future generations of individuals belonging to these groups [140]. He emphasized that it is through story and language that individuals who belong to distinct cultural groups transmit messages about social norms and the meaning of various culturally constructed concepts, including gender, class, and mental health, to its members. According to this framework, there is no such thing as "reality," but, instead, an interpretation of reality that is weaved into a narrative construction. Therefore, a narrative that conveys how people perceive themselves and their situation is thus "constructed" through culturally mediated social interactions [141]. Therefore, narrative therapy focuses on the ways in which individuals construct meaning and is organized according to two organizing principles: personal narrative and social construction. As previously mentioned, a narrative therapist would explore those internalized narratives of his/her patient that are saturated with problems and reflect the dominant narrative of his/her patient's society. The aim of the therapist is to ultimately help the patient separate himself/herself from these problem-saturated narratives that are replete with destructive cultural assumptions and help him/her create a more constructive narrative. By questioning these assumptions and challenging negative internalized stories of discrimination and inequality, narrative therapists enable patients to become active authors of their lives. Some of the techniques that are used to deconstruct negative narratives and construct positive ones include externalization, reframing, use of metaphors, and the identification of unique outcomes. As previously mentioned, the Latino population is composed of many cultures, races, historical backgrounds, immigration histories, and acculturation processes, all of which suggest that a narrative approach is imperative for mental health providers to understand in order to develop cultural sensitivity toward this group.

The stories or narratives resulting in immigration to the USA (reasons for and context of immigration such as political asylum and financial motivations) play an important role in adapting to the host culture [65]. A Latina who is not keen on migrating to the USA following her husband's job relocation, for example, will interpret and process her experiences and adaptation in a markedly different manner than another person who immigrates as a political refugee or as an undocumented individual. Therefore, exploring the patient's migration history and acculturation experience will help both the therapist and the family's "external cultural landscape" [31, 27, pp. 19–20]. Furthermore, the migration experience of Latinos from different countries may vary dramatically because of the social and political histories of their native countries [43]. Evidence suggests that Latinos from Central America predominantly migrate from war-torn countries, placing them at higher risk of developing post-traumatic stress disorder (PTSD) [142, 143], while Latinos from other regions might, instead, may solely experience discrimination. In addition, although Puerto Ricans have US citizenship, many still experience prejudice from non-Latino Whites that fail to acknowledge their citizenship [143]. As such, migration histories and acculturation processes affect mental health outcomes among Latinos [31] and thus warrant attention from mental health providers.

General Latino Characteristics and Other Mental Health Factors

There are a few general Latino characteristics that should be considered when working with this diverse group in a clinical setting. In this chapter, we will provide a review of many Latino-associated traits but understand that it may come across as overly reductionist and/or stereotypical. See Table 11.1 for a synthesis of the differences between Latinos and non-Latino Whites [25, 26, 31, 143, 144]. As noted, despite their heterogeneity, Latinos share many commonalities, including the use of Spanish as a common language and religion, and most share similar cultural values, which will be discussed below.

Acculturation and Acculturative Stress

Acculturation and acculturative stress are widely debated concepts since their meaning and assessment lacks methodological uniformity [25, 145, 146]. These traits, however, are generally associated with language proficiency (poor or limited proficiency has been related with more acculturative stress), years living in the host country, perceived discrimination in the host country, cultural compatibilities, and immigrant commitment to culturally mediated values and behaviors deemed protective, such as familial cohesion. According to the immigrant paradox, the less acculturated the immigrant the better their mental health; this varies, however, by Latino ethnic group and disorder [78]. To formulate more accurate diagnoses and culturally sensitive treatment plans, it is imperative that mental health professionals explore acculturative stress with their patients. It is also important to explore the patient's age of migration, educational attainment, and level of fluency in both Spanish and English. Per Santiago-Rivera et al. [26] in a survey of Latinos conducted by *The Washington Post*, the investigators found that "Latinos who retained dominant use of the Spanish language have a more traditional value structure than those Latinos who are bilingual." Language is,

Table 11.1 Cultural differences between Anglo-Americans and Latinos

Anglo-Americans	Latinos (as)
Individualistic perspective	Collectivist perspective
Nuclear family oriented	Extended family oriented (protective factor)
Individualism (autonomy independence)	Familismo (family connectedness/interdependence) Support lifelong parent–child cohesion
Egalitarian (horizontality)	Hierarchy (verticality)
Emphasizes personal authority	Use of pronouns of respect such as usted, señora, señor, don, doña
Autonomy from parental approval as hallmark of optimal adult development	Respect for parental authority persists throughout life, e.g., not talking back
Encourage to speak their own mind	Spanking more acceptable form of discipline
Less tolerance for spanking	
Emphasizes non-blood relationships (wife–husband)	Emphasizes blood relationships (mother–child) Lifelong bond among siblings
Confrontation and competition	Affiliation and cooperation
Need for more space	More physical closeness
Low context communication (relies primarily on the explicit verbal part of the message)	High context communication (relies more on nonverbal communication)
Direct communication	Indirect communication (use of third persons, allusions, proverbs, metaphors, jokes, and stories to transmit information)
Business like (task oriented)	Personalismo (high level of emotional resonance and personal involvement with family encounters or friends)
	Emotive style, person oriented
	Patriarchal (machismo)
Dignity of the individual: focuses on the external qualities (values achievement)	Dignity of the individual: focuses on the inner qualities (experience self-worth regardless of worldly success or failure)
Structure and task oriented	Spontaneity in interpersonal relationships, serendipity, chance
Predominantly protestants (use of priests, ministers as intermediaries)	Predominantly Catholics (use of saints as intermediaries)
Do not emphasize supernatural forces	Importance on the spiritual domain (supernatural forces)
Internal locus of control	External locus of control (view by Anglos as fatalismo) Attribute the control of life events to luck, supernatural forces, acts of God, or other external forces
Externalizing conversations: outer externalization (talking about problems as they can be defeated/control)	Externalization conversations:
	Inner externalization (talking about a problem as it will be necessary to coexist with it)
	Encourages accepting or being resigned to problems

therefore, an important factor to evaluate and to consider when working with this population. According to the "acculturation gap hypothesis," immigrant children and their parents acculturate at different rates leading to acculturation gaps [147] that can cause family conflict and, in turn, have a negative impact on immigrant children. In a study examining the link between parent–youth differential acculturation and likelihood of substance use in Latino youth, acculturation gaps were associated with increase family discord and less effective parenting practices, which, in turn, were related to increase in future substance use likelihood among Latino youth [148]. As such, it is clinically important to explore the "meaning" each family member assigns to his/her experience of identity and adaptation as differences between individuals can contribute to family dysfunction [26, 31]. For example, a first-generation Latina mother who immigrated to the USA 15 years ago might have more difficulty adapting to American cultural demands as compared to her US-born children. More specifically, if she is less proficient in English than her children, intergenerational conflicts and power struggles might ensue. As such, identifying different levels of acculturation among family members and their adaptation expectations in the USA might help a family reframe its problems, regain cohesiveness, and create a more constructive narrative.

Familismo

As Santiago-Rivera et al. [26] note in their book on counseling, *Latinos and La Familia*, "family is the heart and soul of Latino culture" ("la familia es el corazón y espíritu de la cultura Latina," p. 19). Latinos are family oriented and thus maintain family connections, or "*familismo*." Latinos encourage interdependence, cohesiveness, and cooperation among family members. Latino families, for example, do not expect children over the age of 18 years to move out of their house, instead supporting lifelong parent–child cohesion [31]. This connectedness and interdependency among Latinos are qualities that are sometimes erroneously interpreted by Anglo-Americans as a sign of pathologic codependency [26, 143]. As Falicov [31] states, "the process of separation/individuation, so highly regarded in American culture, is deemphasized in favor of close family ties, independent of age, gender, or social class" (p. 175) among Latinos. They share a collectivistic perspective that places greater value on familial needs over individual ones [149–151]. Family ties extend to aunts, uncles, cousins, grandparents, godparents, and even to close friends. When considering who could be included in the patient's treatment (family therapy), careful consideration should be given to extended family members. Members of the extended family, especially grandparents, play a central role in raising grandchildren and in mediating conflict resolution [26, 150]. Maintaining family ties and connections appears to be protective against psychiatric disorders in Latino adults and adolescents. In fact, family disruption and conflict are associated with an increased risk of mood disorders among Puerto Ricans [152] and SUDs among Mexican American adolescents [153]. In a population-based study of psychiatric disorders in children, Bird et al. [154] concluded that familial attachments protected Puerto Ricans living in Puerto Rico against antisocial and disruptive behavior disorders in children. Similarly, Wahl et al. [155] showed that greater positive family relations had a protective effect among Mexicans and Puerto Ricans, reducing the odds of alcohol use and binge drinking, but were in fact a risk factor for Cubans, increasing the odds of alcohol use and binge drinking. Per Santiago-Rivera et al. [26] reliance on family and community networks could serve to buffer the negative consequences of discrimination in employment, education, and housing for Latinos.

Adopting a collectivistic perspective might be difficult for Anglo-Americans, who hold a worldview that emphasizes individualism, competition, and independence [25]. Mental health providers should be cautious not to impose this perspective on Latinos as it might contribute to poor treatment adherence and lower retention in care. For example, a therapist's emphasis on a patient's personal growth at the expense of family well-being might propagate this individualistic, independent perspective. More specifically, if a therapist were to encourage a young adult Latina to move out of her house, become more independent, and concentrate more on her individual goals than those of her family, this could unwittingly create an internal conflict within the patient and lead to her prematurely terminating care. A more culturally sensitive approach to this clinical situation would be to encourage the patient to explore how to accomplish her goals in a manner consistent with her cultural and familial values, thereby preventing treatment dropout. Helping patients develop solutions consistent with their values may result in better clinical outcomes. According to Bernal et al. [136] "interventions that take into consideration the role of family, spirituality, language, and acculturation are likely to augment engagement and retention and to produce positive outcomes (p. 323)." Hence, evidence suggests that because of "familismo" and maintaining a collectivistic perspective, Latinos are often more responsive to treatment approaches that incorporate family members, perspectives, or values [156].

Personalismo

Personalismo refers to the value placed on building interpersonal relationships by Latinos. Personalismo emphasizes warmth and friendliness over formality and detachment and is characterized by a high degree of emotional and personal involvement between family members and friends [157]. Latino patients may express themselves in a highly emotive manner during a mental health encounter, instead of adopting a task-oriented demeanor or presenting as emotionally detached. Latinos value connectedness with their provider and may ask personal questions of their provider. This behavior should not be interpreted as a possible boundary violation; instead, it is a culturally accepted behavior that views self-disclosure as a means for fostering warmth within a relationship [26, 151]. Many scholars suggest that therapists engage in small talk, or "pláticas," that include judicious self-disclosure to promote *personalismo* and thus enhance the therapeutic relationship [25, 26].

Another manifestation of *personalismo* is affection [158]. The degree of physical proximity permissible by Latinos is very different than that of Anglo-Americans. Latinos tend to be more comfortable with closer physical proximity than that typically accepted by Anglo-Americans. For example, if a Latino patient were to place his or her chair closer to his or her therapist during a psychotherapy session, this should not be interpreted as a boundary violation, but instead as a cultural expression to enhance comfort. Many Latino groups, particularly those from the Caribbean and the coastal areas of Latin America, tend to be more expressive and uninhibited in communication style [26]. They value expressions of *cariño*, or terms of endearment, either verbally or nonverbally, as a mean to foster the relationship. Some verbal expressions of *cariño* between family members and friends include diminutive terms such as "mi amorcito" (my little love), "negrita" (little Black woman), and "negrito" (little Black man). Nonverbal demonstrations of *cariño* include kissing on the cheek upon greeting, touching the person while talking, and hugging. The patient may use expressions of *cariño* during the therapeutic process; providers should be aware that they are a cultural expression of appreciation. For example, some counselors or therapists might feel uncomfortable if, at the end of a session, a patient approaches them with a goodbye kiss on the cheek or a touch on the shoulder as a demonstration of gratitude. This could create an ethical dilemma for therapists who fear that these actions risk breaking boundaries between the patient and therapist. In these instances, it is recommended that the therapist act prudently and evaluate his or her own cultural belief system. Another related issue involves the giving of gifts on behalf of the patient. As a means of expressing appreciation, a Latino patient might choose to give a gift to his or her therapist. This, too, may represent an ethical dilemma for the therapist; hence, it is important that the therapist be aware that it is a common practice among Latinos to offer gifts as a token of their appreciation. If the therapist were to reject a gift from a Latino patient, the patient might interpret the therapist's action as rude or as a sign of rejection [147]. Therefore, it is important that the therapist assess the reasons why the patient could be offering the gift. In general, patients' gifts usually represent a token of appreciation and are typically inexpensive, such as a souvenir or native food from their country. If the gift offered is expensive, the therapist should discuss the meaning of the gift with the patient before rejecting it.

Respeto

Another value that Latinos highly esteem is *respeto*, or respect. For Latinos, being respectful and considerate toward others is very important. The value of *respeto* refers to the way one should treat others and is a means of establishing boundaries and hierarchy [159]. Obedience and respect for parental authority and family bond are values that are highly stressed in traditional Latino families. Therefore, Latino adolescents often struggle with incongruence between social norms taught at home, based on respect for authority and elders, and American-based same age peers' norms, centered around individualism and independent achievements.

Latinos typically employ a hierarchical communication style, while Anglo-Americans typically employ a communication style that is more egalitarian [25, 26]. The hierarchical communication style used by Latinos is manifested and supported through language using specific pronouns. For example, authority figures, parents, and elders are generally addressed with respect using the formal second person *usted* (*you*), instead of the informal second person *tú* (*you*). Titles of *Don* (for males) and *Doña* (for females) are used by both younger adults and children before an elder's first name (i.e., Doña María) as a way of demonstrating respect [147]. Other formal pronouns used are señor (Mr.) and señora (Mrs.). It is worth commenting on the fact that Latinos from South American countries such as Argentina, Uruguay, and Chile might not be comfortable with using more formal pronouns since they usually use "vos" (Argentina) or "tu" (Uruguay, Chile), instead of "usted." Therefore, providers must take a curious stance about a patient's heritage and cultural background asking patients directly about their preferences, instead of making assumptions that can negatively impact the therapeutic relationship. When commencing therapy with a Latino patient, it is important that the therapist address the patient in more formal manner using the pronoun, "*usted*," as a way of demonstrating respect until the patient expresses the preference that he or she be addressed more informally. It is also important to note that some Latino ethnic groups, such as the Dominicans, do not look directly at their therapist when in treatment because it connotes a lack of respect toward authority figures. This nonverbal communication is an example of the cultural value placed on respect. Providers should not label this behavior as denoting low self-esteem; instead, it should be interpreted as a cultural demonstration of respect for authority.

Spirituality

Spirituality is a critical value among Latinos. Religion and spirituality play an important role in the everyday life of Latinos [26, 148]. Although a wide range of Christian denominations have proliferated, the predominant religion among Latinos is Roman Catholicism [26]. While the Pew Research Center's 2013 National Survey of Latinos and Religion found that 55% of adult Latinos identify as Catholics, nearly one in four Latino adults (24%) is now a *former* Catholic [160]. Comparing the 2013 survey results to data gathered by the Pew Research Center in 2010, there has been a decrease in terms of Latinos self-identifying as Catholics from 67% in 2010 to 55% in 2013 [160]. Some religious celebrations include: Catholic *bautismo* (baptism) and "*Dia de los Muertos*" (Day of the Dead). The second is a Mexican ceremony to remember loved ones who have passed away. Other religious festivities include first communions, marriages, funerals, and the Holy Week before Easter. Some Caribbean Latino countries also practice *Santería*, a fusion of Catholicism and African traditions. Latinos may seek help from traditional folk healers such as *santeros* (Cuban), *curanderos* (witch doctors or brujos/Mexican), and *espiritistas* (Puerto Rican) to deal with health and mental health problems [26, 161].

It is common to see altars in Latino homes with statues of favorite saints, pictures of deceased family members, and lit candles. If a family member is sick or in trouble, Latinos pray, seeking comfort and support in God. It is also very common for Latinos to rely on a higher power (e.g., God) to create meaning out of various life experiences. This is particularly true when trying to achieve goals in life [26, 148]. For example, the expression "si Dios quiere" (if it is God's will) exemplifies this. In addition, when things do not have the outcome expected or when tragedies occur, a Latino might say: "Dios sabe lo que hace" (God knows what he does) or "no hay mal que por bien no venga" (referring to some good may come out of bad things) or "no era de Dios" or "Dios no quiso que fuera" (it was not God's will, God did not want it to be). This emphasis on spirituality has been misinterpreted by many Anglo-Americans as "*fatalismo*" or as Latinos having a more fatalistic perspective of life. Anglo-Americans might interpret the reliance on a higher power as a sign of resignation.

For example, Anglo-Americans typically emphasize that one rely on the internal qualities of will power or perseverance, while Latinos rely on a higher power to help them confront painful circumstances in life [26, 162]. Of note, this does not mean that Latinos do not acknowledge their internal strengths, but instead believe that a spiritual dimension is crucial to making meaning out of life.

The emphasis on spirituality and religiosity among Latinos appears to be related to nativity and acculturation. In the Pew Research Center's 2013 National Survey of Latinos and Religion [160], religion was reported to be more important to immigrants than to US-born Latinos. Approximately 69% of foreign-born Latinos as compared to 51% of US-born Latinos endorsed religion as being "very important." The same survey found that six in ten foreign-born Latinos are Catholic, compared with about half of the US-born Latinos (48%). Therefore, clinicians should be aware of these differences in practice and acculturation and explore the religious preference and practice of each individual patient in a respectful way.

Communication Patterns

Latinos generally rely on high context communication as compared to Anglo-Americans [31]. High context communication is characterized by the predominant use of nonverbal communication; low context communication relies more heavily on explicit verbal messages [31]. Low context communication is associated with communicating in an indirect manner, using jokes, sarcasm, diminutives, allusions, proverbs, metaphors, parables, and the use of the third person. For example, during a couple's therapy session, a wife might tell her husband, "palo que nace doblao, jamás supo que enderezca" ("a tree that has grown bent cannot be straightened"), referring to her perception that he will never change. Also, a Latino might say "one could be angry at…," instead of more directly stating, "I am angry at you." This is because some Latinos believe that direct communication (i.e., assertiveness), especially if it expresses a negative emotional state, is rude or insensitive. As such, Latinos rely more heavily on indirect communication to denote conflict or differences [31].

Addressing patients appropriately can be challenging for some providers further exacerbating cultural distance between the provider and patient. For example, it is quite common for Latinos to have combined names and last names which can be confusing for US practitioners who are used to one name and surname. Many Latinas have combined first names such as "María Luisa," "María José," and "Ana María," but are often addressed by providers as simply "María," leading to the possibility of tension between the patient and provider and even be taken by the patient as culturally insensitive. The same problem can apply to Latinos who have combined names like "José Ignacio" or "Juan Francisco"; if the patient goes by their first name only omitting the second name, it can be taken as offensive and lead to confusion since some patients might not respond to providers calling them only "María" or "Juan" if their name is, for example, "María Inés" or "Juan Carlos." Double or hyphenated Latino surnames may also seem complicated, with the father's name preceding the mother's last name, but Latinos usually appreciate when they are called by both names and/or both last names. Not addressing patients by their given/preferred name or surname can be considered a microaggression that can jeopardize the therapeutic relationship. When in doubt, the best approach is to ask the patient how he or she would like to be addressed.

Positive emotional expressiveness among Latinos is characterized by warmth, physical closeness, gesticulations while talking, and the use of terms of endearment to compliment friends and family members. Many Latinos are also thought to speak in a louder voice when emoting.

Due to the high level of indirect communication used by Latinos, therapists should use metaphors as a technique in engaging this population. Narrative therapy uses stories and metaphors to break down destructive cultural assumptions and construct new and more positive views. For example, Garcia-Preto [163] uses the metaphor of a bridge to help Latina patients deal with the dilemma of living between two cultures. As Garcia-Prieto [163] relates:

> I am able to share the metaphor of the bridge as a safe place to understand the world in which they [Latinos] grew up and the possibilities of the new world they have entered. When I help people construct the bridges they need for this journey between cultures, my own bridge becomes sturdier and wider (p. 273).

Many Latinos live between two cultures, that of their country of origin and that of their host country. The acknowledgment that cultures are not static, but are instead in constant flux, helps one understand the identity development of Latinos living in the USA from a social constructionist perspective (narrative perspective) [163, 164].

A narrative framework works well when applied to a minority or multicultural framework because it emphasizes a view that is contextually historical and political. As mentioned previously, the focus of narrative therapy is to deconstruct established truths that oppress a group of people. How Latinos as a group are perceived and the negative connotations given by the dominant culture may lead to the development of a problematic identity narrative that contributes to the cycle of oppression and discrimination. Negative personal narratives, however, can be broken down and reconstructed. The narrative model emphasizes the strengths of a given individual; when problems are identified by the therapist, they are then externalized to help patients realize the toxic effects cultural narratives have on their negative identity narrative.

For example, an adolescent Latino who drops out of school to help sustain his family financially may have internalized a negative cultural dominant narrative of prejudice. This narrative, in turn, leads him to believe that he may never reach his professional goals in society since most Latinos are "failures" or have difficulty accomplishing their goals. He might even believe that because he is not fluent in English, he is not intelligent and will never attain a university education. His self-constructed story might be that just because he is *mestizo*, he will never succeed in the USA, which could lead to his holding insignificant jobs or trafficking drugs. The people he cares for are in gangs and sell drugs, and the people that oppress him are ones that perceive him as lazy, dumb, and a loser, getting him into a double bind (no win situation). He is frustrated and loses his temper easily, which leads to him getting into fights with others in the neighborhood and mostly with individuals that are non-Latino Whites. A narrative therapist should explore his family migration story, his level of acculturation, his preferred language for treatment, his construction of self, his individual strengths, and instances of positive outcomes, including times when he resisted being aggressive or behaved in a way that contradicted the story he tells himself about his identity. This adolescent's self-identity as a failure should be analyzed in terms of negative internalized cultural narratives that emphasize oppression. To deconstruct these assumptions, the therapist could ask the adolescent how he came to believe that Latino men could never be intelligent or successful in the USA.

The narrative therapist might also use the technique of externalizing the problem by telling the adolescent: "When you feel overtaken by bad temper [emphasizing that the bad temper, not adolescent, is the problem], what does it make you do?" This technique separates the problem from the person, thereby helping the adolescent develop a more positive view of himself. The therapist should also explore unique outcomes (behaviors that are exceptions to the negative dominant story) that can help him create a more positive story of himself. For example, the therapist might explore and highlight occasions during which the adolescent was respectful toward others, considerate, peaceful, and successful in school, as a way of constructing an alternative story of success and possibility. The therapist could also include *dichos* (proverbs) or metaphors to help the patient develop a more positive self-image. An example of a treatment that uses narratives is *Cuento* therapy, which has been shown to be effective in treating symptoms of anxiety and post-disaster trauma among Puerto Rican children and adolescents in New York City. *Cuento* therapy is a form of child psychotherapy in which Puerto Rican mothers recount folktales from Puerto Rican culture to their children (refer to Costantino et al. [165, 166] for more details).

A narrative therapist assumes a stance of being "humble" and respectful, emphasizing a collaborative perspective between the therapist and patient, instead of an "expert" stance. This shift toward a more collaborative stance fosters patients' empowerment, making this model suitable for working with disenfranchised populations. Acculturative stress and problem definition are constructions that are in constant flux; as such, identity construction is constantly changing. Using a perspective that values change takes the environment (context) into account, and the family and political challenges that affect people under consideration are critical to working efficiently with a minority population.

Other culture-centered family therapy models that have been effective with Latinos include the Bicultural Effectiveness Training model (refer to Szapocznik et al. [167] for more details), the Multidimensional Ecosystemic Comparative Approach (refer to Falicov [31] for more details), and Bowenian models (refer to Inclan and Hernandez [168] for more details). Santiago-Rivera et al. [26] also suggest the use of culture-centered genograms as a systemic and ecological assessment tool. Using genograms, a technique used in family therapy to collect information about three generations, the therapist can encourage the development of new narratives in a non-threatening way and better understand the migration history, family struggles, and coping patterns that exist in Latino families [26]. For other evidence-based culturally adapted treatments for Latinos, refer to Bernal et al. [136] and Bernal and Domenech-Rodriguez [169].

Conclusion

Latinos are the fastest-growing minority group in the USA. Because their growing demand far exceeds the service capacity able to address their needs, Latinos suffer marked disparities in education, mental health, and healthcare utilization as compared to non-Latino Whites. In addition, they are less likely than non-Latino Whites to remain in treatment [22]. There are also significant differences in the prevalence of mental health disorders and SUDs as compared to non-Latino Whites [21, 43].

A growing demand for care coupled with high unmet need represents a significant challenge to Latinos as they confront extensive service disparities [7, 8]. To increase Latinos' adherence to treatment, it is important that mental health providers understand and be sensitive to the cultural nuances of this population. For example, cultural values of *familismo*, *personalismo*, *respeto*, and *spirituality* are highly important to Latinos. Therefore, in the collective experience of the authors, we recommend family therapy as the preferred treatment choice for Latinos or shifting from an individualistic perspective to a more collective one when treating Latinos. This could represent a challenge for mental health providers that hold an individualistic perspective. It is equally important that mental health providers be cognizant of the fact that Latinos hold a more hierarchical communication style that is conveyed using language that implies respect. Latinos also typically use more nonverbal communication, including body language, hand movements, and tone of voice, to express themselves. In addition, Latinos use more covert methods of communication such as metaphors, stories, and *dichos* (proverbs) or *indirectas* (indirects) to convey meaning. Therefore, it is recommended that Spanish providers be used during therapy as a technique to enhance the therapeutic alliance. In addition, due to the heterogeneity encountered in the Latino population, mental healthcare providers should familiarize themselves with the historical, cultural, and political experiences of prejudice, discrimination, and sense of disenfranchisement experienced by Latinos living in the USA [156]. Even though inconsistent findings have been found with ethnic matching, it would be optimal that therapists who work with Latinos be bilingual, culturally sensitive, and cognizant of their own biases and perspectives when working with this population. We also recommend using a narrative perspective that emphasizes the use of positive stories instead of ones that emphasize prejudice, oppression, and disenfranchisement. Helping Latino patients living in the USA construct more positive stories of themselves will serve to empower them, thereby promoting a culture of belonging, sensitivity, equality, and peace.

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12

Not by Convention: Working with People on the Sexual and Gender Continuum

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Introduction

The Continuum Approach: Battle Cry for a New Generation of Clinician-Activists

We chose the title of this chapter with clear intent. How many LGB, LGBT, and LGBTQ scholarly works have you read in the pursuit of understanding of how gender and sexuality develop through the lifecycle, affect physical and mental health and well-being, and impact social discourse, policy, and law? In January 2017, the *National Geographic* published a Special Issue entitled, "Gender Revolution," highlighting how resilient our younger generations are in moving beyond traditional, dichotomous categories and living life on the gender and sexual continuum.

The topics covered in the Special Issue reflect just how far ahead youth raised during this "gender revolution" are in understanding and living on the spectrums of gender and sexuality. From school-age childrens' insight into the limits placed on them based on their gender to the stigma associated with paid paternity leave, the Special Issue illustrates how our social attitudes toward gender and sexuality have a meaningful impact across generations and cultures. Rethinking gender in a rapidly evolving social climate driven by social media and increased visibility for gender and sexual minorities requires shifts to our knowledge base as providers. The "Discussion Guide for Teachers and Parents," provided by the Special Issue, opens with a "primer" of relevant definitions and helpful questions to clarify how complex the development of gender and sexual identity is universally [1, 2]. It is no surprise that readers are encouraged to consider how culture, language, region, biology, and numerous other factors contribute to the many self-defining labels created by young people to capture the vast range of sexual and gender expression and identification.

We wrote this chapter with "all of the above" in mind and hope that you find the following principles and pearls, in some way, applicable to every patient encounter, team meeting, research protocol, and your own evolving perspectives. The chapter begins with an introduction to seven guiding principles for working with people on the sexual and gender continuums, followed by a brief review of key historical periods within our field and DSM-5 changes. The chapter explores developmental considerations, assessment within

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a biopsychosociocultural framework, comorbid medical and mental health concerns, the impact of minority stress, and considerations for those who are multiple minorities. Finally, we offer clinical pearls to consider in treatment and special considerations for gender variance.

Seven Guiding Principles

1. Gender and sexuality exist in continuums with infinite possibilities, not in discrete, mutually exclusive categories, such as male vs. female vs. transgender and heterosexual/straight vs. homosexual/gay/lesbian vs. bisexual vs. asexual.
2. The gender and sexuality continuums are separate, yet interrelated realms. For example, consider a trans-man (female to male transgender person) who is married to a woman and self-identifies as heterosexual. The basic concept of sexual orientation relies, by definition, on gender considerations. This individual may have identified as lesbian in adolescence and following his gender reassignment now identifies as straight.
3. The gender continuum breaks down into separate, but not mutually exclusive, masculine and feminine continuums. Each individual, regardless of biologic sex, may embody a combination of male- and female-stereotyped traits, behaviors, roles, and identifications.

   For example, a biologic male, who is a husband and a father, may play a more nurturing, emotionally expressive role within a family, while his biologic male partner may play a more assertive, analytic role. Consider the balance of masculine- and feminine-stereotyped traits embodied by a lesbian, scientist mother, who leads a research program but has chosen a flexible work schedule, so that she can be home for school pickup and family activities.
4. Sexuality is composed of three distinct realms: orientation and attraction, behavior, and identity. These three realms are interrelated but not always aligned.

   A man, who is attracted to and has sex with both women and men, may identify as heterosexual. A woman, who is attracted to both men and women and is married to a woman, may identify as lesbian in her twenties but make a conscious decision not to label herself during the rest of her adulthood.
5. Gender may develop based upon biologic sex, but this is not always the case (i.e., transgender, intersex, androgynous individuals). Gender can be broken down into gender identity, roles, and presentation as well as other realms of gender expression both within and outside of the context of culturally defined norms.
6. There are biological, psychological, social, and cultural influences at play in gender and sexual developmental trajectories. The strength and salience of these influences fluctuates as one moves through the lifecycle.

   For example, biological influences such as genetic factors and hormonal influences play a strong role during prenatal and pubertal development. Social factors, such as family and peer relationships, robustly shape behavior during the preschool and school-age years.
7. Each individual is unique and composed of multiple identities that exist within and interact with other sociocultural realms, such as socioeconomic status, geographic region, race and ethnicity, religious and spiritual affiliation, and gender and sexuality, among others.

Figure 12.1 offers a simple visual scale to use in clinical encounters. Across the top of the figure, there are two continuums, male/masculine and female/feminine, with intensity scales ranging from 0 to 10. Below, there are four realms of assessment—gender identification, gender role and expression, sexual attraction, and sexual behavior—to inquire about during the course of your work with each client. Each of these realms will be explained further in subsequent sections. The integration of these four realms makes up one's consolidated sexual and gender identity.

Throughout the chapter, we will be utilizing the cases of BA and SL to illustrate key concepts

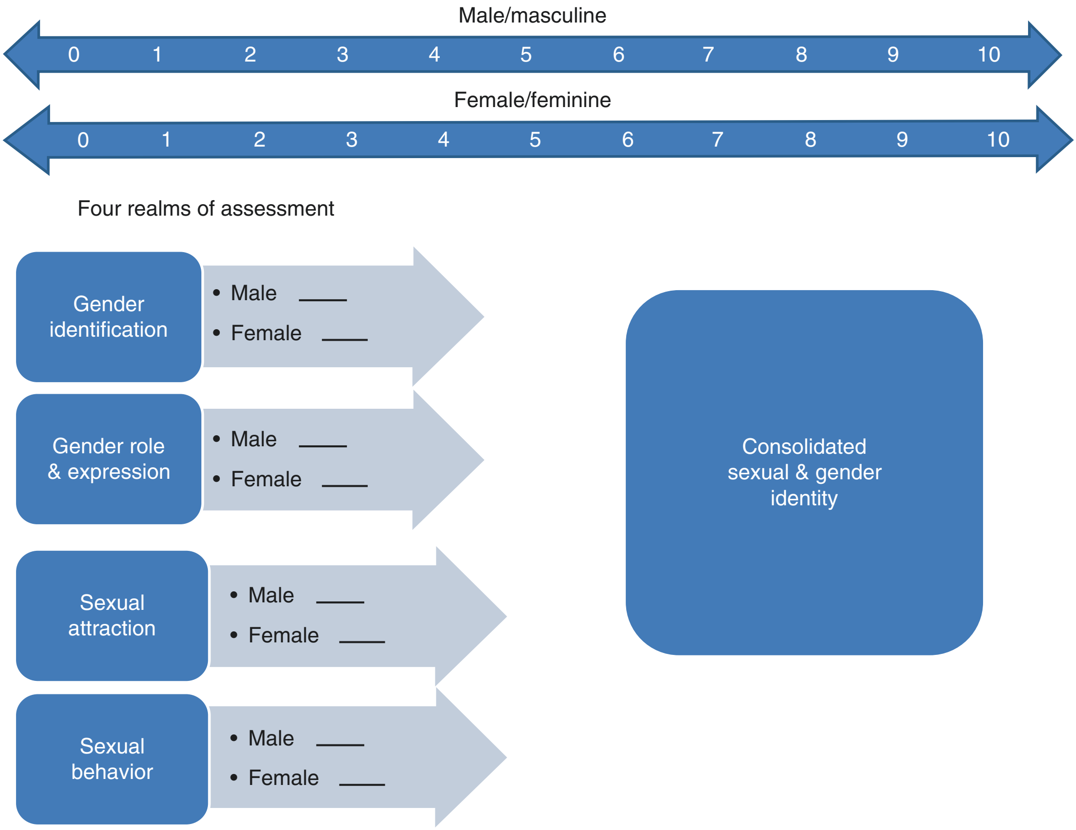

Fig. 12.1 Gender and sexuality assessment tool

and provide recommendations for assessment and treatment.

> BA, a 13-year-old assigned female at birth, presents for an initial psychiatric assessment after increased anxiety and panic attacks in the context of anticipating the start of a new high school. Three months into treatment, BA reports that while they are uncomfortable attending a new school, they also are intensely uncomfortable in their body, expressing that they identify as agender.
>
> SL, a 17-year-old assigned female at birth, presents for an initial psychiatric assessment after recently disclosing to his mother and father that he prefers male pronouns, would like to start using a gender-neutral name, and is interested in starting hormone therapy to present as more masculine in college. SL meets weekly with a psychologist to address symptoms of social anxiety and depression, as well as intermittent non-suicidal self-injurious behaviors (NSSIBs). SL and his parents expressed concern about his current therapist's lack of sensitivity to the possible impact of Gender Dysphoria on his current mental health challenges.

Historical Context

The field of medicine has a checkered and storied past when it comes to understanding sexual orientation and gender identity. As far back as the late 1800s, physicians such as Magnus Hirschfeld began to conceptualize sexual orientation and gender identity as biological variance rather than as criminal. Meanwhile, contemporaries such as Karl Westphal argued that homosexuality was an illness that should be treated [3]. Physicians and psychologists argued among each other and the prevailing theories began to evolve and change over time. Freud brought attention to psychosexual functioning and to the concepts of sexual orientation and gender identity. His ideas about sexual orientation and gender identity changed over time and had a profound impact on theories to come. In answering a letter written by a mother hoping for Freud to cure her son of homosexuality, he wrote:

> Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development. Many highly respectable individuals of ancient and modern times have been homosexuals, several of the greatest men among them (Plato, Michelangelo, Leonardo da Vinci, etc.)… By asking me if I can help, you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way, we cannot promise to achieve it. In a certain number of cases we succeed in developing the blighted germs of heterosexual tendencies which are present in every homosexual, in the majority of cases it is no more possible. [4]

The disagreement within the psychiatric community about homosexuality was not a surprise, nor was it surprising that the prevailing views perceived both variations in sexual orientation and gender identity as illness. The concept of identity as pathology persisted, and by the time the first edition of the DSM was released, homosexuality was classified as a sociopathic personality disturbance (Table 12.1). The time from the 1940s, after the release of the DSM to the 1970s, with the revision of the DSM-II, was an era of great social and academic change. Alfred Kinsey brings light to the notion of sexuality as a continuum and exposes a much higher prevalence of homosexual behaviors than was thought [5]. Evelyn Hooker publishes "The adjustment of the male overt homosexual" and with her elegantly designed study challenges the notion that gay men have more psychopathology than heterosexual men [6]. Gay men and lesbians begin to organize and advocate for their rights, and the 1969 Stonewall riots bring momentum and publicity to the gay rights movement. Concurrently, Bieber and Soccarides set forth the theory of causality of homosexuality as a domineering mother and absent father (Bieber) or as a result of incapacitating childhood trauma [7, 8]. They argue for therapeutic cures for homosexuality, the techniques of which formed the basis for what is now referred to as reparative therapy. Gay men and lesbians began to picket the American Psychiatric Association Conferences and argue fiercely that they are not psychiatrically ill by nature of their sexual orientation. By 1973, the DSM-II is revised to remove homosexuality and replace it with sexual orientation disturbance. However, it is not until 1987 that it is removed completely. Meanwhile, variation in one's gender identity is similarly considered pathology and is currently classified under the diagnosis of gender identity disorder.

DSM-5 Changes

Similarly to how visibility of lesbian, gay, and bisexual people helped to change the medical culture's views of sexual orientation, the increasing visibility of transgender and gender-variant individuals continues to move the field away from pathologizing identities. As a result, significant changes were made to DSM-5 in 2013, and gender identity disorder was removed and replaced with gender dysphoria. In order to avoid stigma and create a more appropriate diagnostic label, the change to "gender dysphoria" highlights the distress that often but does not always come with variability in gender identity. Gender dysphoria is described as "a marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months duration…" [9] and requires clinically significant distress or impairment. As such, while many gender-variant individuals go through a period of dysphoria as a part of development, it is this dysphoria rather than the development itself that is pathologized. The topic of gender variance in childhood continues to be quite controversial and is reflected in the stricter diagnostic criteria for this diagnosis in children than in adults (six positive criteria are required for children as opposed to two for adults).

While changes to DSM-5 attempted to reduce the stigmatization of gender diverse individuals and allow for consistent recognition of these identities in healthcare settings, capturing the complexity and variability of gender and sexuality identity remains a challenge. Despite ongoing controversy and disagreement about the change to gender dysphoria, there is a clear progress in the 60 years since the DSM classified LGBTQ individuals as sociopathic. By examining our

Table 12.1 Sexual orientation and gender identity in the DSM

	DSM-I—1952	DSM-II—1968	DSM-IIR—1973	DSM-III—1980	DSM-IIIR—1987	DSM-IV—1994	DSM-5—2013
Sexual orientation	Sociopathic personality disturbance along with psychopathy: sexual deviation	Sexual deviation: homosexuality	Sexual orientation disturbance	Ego-dystonic homosexuality	Removed from the DSM	N/A	N/A
Gender identity	N/A	Sexual deviation	Sexual deviation	Transsexuality (adults); atypical GID (children)	Transsexuality (adults); GID-NOS (children)	Gender identity disorder	Gender dysphoria

field's interface with sexual orientation and gender identity, we can begin to understand a provider's role in both the potential of creating and/or eradicating stigma and bias and work toward a more open understanding of people on the sexual and gender continuum.

Developmental Considerations and Basic Definitions

As mental health professionals, we are trained to think in a way that incorporates the various influences on a person's life. Biologic and maturational processes, psychological factors, and social and cultural influences all play an important role in the development of gender and sexuality through the lifecycle. Developmental trajectories for gender and sexual minorities likely share more similarities with the general population than differences. However, those areas of difference are also important to highlight given their potential impact on the therapeutic alliance, reluctance or willingness to seek treatment, and physical and mental health outcomes. In this section, we will cover fundamental concepts and stages of life, which play a pivotal role in gender and sexual development.

Gender Development

By the age of 2 or 3 years old, most children have developed a sense of *basic gender identity* and have labeled themselves as boys or girls. Somewhat later, these children develop *gender stability*, meaning that they perceive their gender as being *stable over time*. That is, they predict that boys grow up to be men, and girls grow up to be women. By age 5–7, children typically develop an understanding of *gender consistency*, which allows them to realize that one's gender is also *stable across situations* [10]. Though *basic gender identity* develops during toddlerhood, a deeper understanding of *gender identity*, one's awareness of one's gender and its implications, continues to evolve throughout the lifecycle. The meaning and salience of one's maleness or femaleness transform throughout the preschool years, latency, adolescence, and young adulthood, as well as in the context of intimate relationships, committed unions, parenthood, and later life. One's *gender role*, or one's outward presentation and behavior, is often categorized as either typically male or typically female and also continues to change through the lifecycle. Family, peer, and prevailing societal norms and expectations all play a powerful role in shaping outward manifestations of gender as well as internal conceptions of the self [3, 11].

Biological contributions to gender development include genetic factors and hormonal influences. Money and Ehrardt's biosocial theory describes how genes and hormones influence children's physical development, including their genitalia and secondary sex characteristics, which then in turn influences how they perceive themselves and how others perceive them [12]. Biology also influences gender role development as children typically present with play that often falls more typically in one gender or another. Boys tend to prefer more rough and tumble play, and girls more imaginative and social/relational play [13, 14]. By no means is this a hard and fast rule, as many of us recall or were "tomboys" or "girly boys" growing up, and these early tendencies and preferences do not necessarily dictate future adult gender identity and roles.

The biosocial theory describes a number of critical biological and social episodes or events, such as inheriting either an X or Y chromosome from one's father at the time of conception, the formation of female or male differentiated gonads (ovaries or testes) by week 8 of gestation, and the subsequent secretion or non-secretion of prenatal sex hormones, which impact sex differentiation and gender development. Prior to week 6 or so of development, male (XY) and female (XX) embryos are the same except at the genetic level. Both have the capacity to form either male or female reproductive systems. Around week 8 of embryonic development, the secretion of testosterone and Mullerian inhibiting substance (MIS) by the testes of a male embryo stimulates the development of the male reproductive system and, simultaneously, inhibits the development of the female reproductive system. In the case of a female embryo, the absence of testosterone and MIS leads to the development of the female reproductive system, which is the default state in nature. Around 3–4 months after conception in a male embryo, the ongoing secretion of testosterone leads to the growth of a penis and scrotum. In a female embryo, the uterus, cervix, and vagina develop in a programmed fashion without hormonal control.

Hormones play a particularly prominent role in gender development during the prenatal and pubertal periods. During these sensitive periods of development, exposure to androgens (male hormones) or estrogens (female hormones) may differentially influence one's physiology, chemical processes, and morphology and determine the body habitus, secondary sex characteristics, and, to some extent, brain organization and lateralization of cognitive and language functioning [15]. The combination of biologic and social forces, ultimately, impact gender-related behaviors, roles, and identity. Much of what we have learned in this field comes from work with patients who have genetic and hormonal syndromes, such as Klinefelter syndrome (47 XXY), androgen insensitivity, and congenital adrenal hyperplasia, among others.

Within psychology, many theories have been proposed to explain the process of gender development and differentiation. Given the scope of this chapter, we will highlight a few key conceptual trends. Halpern's model offered a perspective on how nature and nurture might jointly influence the development of many gender-typed attributes, such as spatial skills in males and language abilities in females. Halpern asserted that specific early experiences affect the organization of the brain, which in turn influences one's responsiveness to similar experiences in the future. For example, due to social conventions and gender norms, boys who receive more opportunities to engage in spatial reasoning and explore a wider variety of spatial experiences may develop a rich array of neural pathways in the brain's right cerebral hemisphere that serve spatial functions, which in turn may make them even more receptive to spatial activities and acquiring spatial skill. In contrast, girls may develop a richer array of neural pathways in areas of the brain's left cerebral hemisphere serving verbal functions, thereby becoming even more receptive to verbal activities and acquiring verbal skills [12].

According to the social learning theory, children acquire their gender identities and gender role preferences through differential reinforcement and observational learning. Through differential reinforcement, children are encouraged or rewarded, implicitly or explicitly, for gender-appropriate behavior and discouraged or punished for gender-atypical behavior. Through observational learning, children adopt the attitudes and behaviors of a variety of same-sex models [10]. Numerous studies have shown that even before the age of 2 and before children have acquired their basic gender identities, parents are already differentially reinforcing their children's interests and behaviors by rewarding those that are gender-appropriate, such as praising a boy who is playing with trucks and blocks, and discouraging those that are gender-atypical, such as admonishing him when playing with dolls or dressing up [12].

Social and cultural factors begin to influence the complex and lifelong process of gender development even prior to birth. What color will the baby's room be painted? What name have the parents chosen? Why does the infant clothing color palette shrink to pink and blue? Without gender-specific colors, clothing, hairstyles, and names, we would be hard-pressed to distinguish between baby boys and girls through their first year or two of life (and arguably up until puberty). The socialization process continues with parents tossing their baby boys into the air and cuddling their baby girls on their laps. Early in life, parents and caregivers certainly provide the strongest social influence on gender development, but during the preschool years and beyond, peers and siblings begin to exert a more significant influence. Popular culture and media also play powerful roles in shaping our ideas about gender roles and expectations, limitations and possibilities, and models for identification.

There are vast differences across cultures in what people expect of boys and girls. In Tahiti, few distinctions are made among males and females; even the national language lacks gender pronouns, and most names are used for both boys and girls. Anthropologist Margaret Mead found varying patterns of masculine and feminine traits in the members of three different “primitive societies” living in New Guinea. According to Mead’s observations, the Arapesh and Mundugumor both made limited distinctions between males and females; however, gender expectations varied enormously between the two. The Arapesh idealized stereotypically feminine traits, such as cooperation, sensitivity, and submissiveness. On the other hand, Mundugumor men and women revered aggression, violence, and stoicism, which are typically regarded as masculine traits. Finally, in the third society Mead observed, the Tchambuli, women were expected to be dominant and exhibit a limited amount of emotion and men were regarded as more dependent, emotional, and irresponsible. Mead points out that the Tchambuli’s gender expectations are the opposite of those found in Western cultures [12, 16].

In the Native American/First Nation culture, individuals may identify as being *two-spirits*, which refers to people who are either biologically male and fulfilling the social role of a woman or biologically female and fulfilling the social roles of a man. Native Americans dissociate physical or biological traits from gender within the two-spirit identity and, instead, emphasize the role of spirituality in creating gender. Two-spirits are considered as having embodied both male and female spirits [17–19]. In some Native American communities, these two-spirits are revered and celebrated for their superior spiritual status and ability to see through both the male and female perspective. That being said, this celebration is not always the case [18, 20]. Regardless, the two-spirit identity exemplifies the ways different social and cultural forces like spirituality can shape gender expression and identity.

In Kosovo, homosexual Gypsy musicians use music to negotiate the arbitrary boundary between male and female genders. Cultural forces like religion and socioeconomic conditions shape the ethnomusical experiences in this society [21]. Male musicians may perform for the public accompanied by instruments, whereas women are typically restricted to private domains with female audiences. *Talava*, a specific type of Gypsy music that originated in the female domain, is performed in public by homosexual men who dress and behave like women. Based on their unique behaviors and established social standing, one can argue that these individuals inhabit a third gender space within the local culture [21].

Sexual Development

Empirical research reveals that human beings are sexual beings throughout the lifecycle with sexuality manifesting itself in diverse and complex ways at different points in time. DeLamater and Friedrich assert that the capacity for a “sexual response,” as manifested by erection and vaginal lubrication, is present from birth. These physiologic responses as well as infant exploratory touching of their genitals can be seen within the first 2 years of life. Around age 2.5–3 and sometimes earlier, the rhythmic manipulation associated with adult masturbation can appear and is a natural form of sexual expression. Between the ages of 3 and 7, there is marked increase in sexual curiosity and exploration, such as “playing house” and “playing doctor” with similar-aged peers. Through the elementary school years, ages 6–9, sexual play becomes increasingly covert as children become aware of cultural norms.

During preadolescence, ages 8–12, children tend to socialize and learn about sexuality with same gender peers. This social organization changes dramatically during adolescence as teens progress through puberty. During puberty, there is sudden enlargement and maturation of the gonads and genitalia, development of secondary sex characteristics, and surge in sexual interest due to increases in testosterone levels and a growing capacity for adult sexual interactions. The process of achieving sexual maturity continues through adulthood through committed and/or noncommitted intimate relationships. Later in life, women may undergo physical and emotional changes associated with menopause as men progress through andropause. These changes, however, do not preclude older people's ability to engage in satisfying sexual activity in all forms [22].

Sexuality can be broken down into three domains: sexual attraction and orientation, sexual behavior, and sexual identity. *Sexual orientation* refers to the predominance of erotic thoughts, feelings, and fantasies one has for members of a particular sex. This also includes the intensity of one's sexual attraction toward members of the same or opposite gender and with whom one tends to fall in love. *Sexual orientation* may be fixed at birth or an early age and is considered to be "immutable, stable, and resistant to conscious control" [23]. Based on our current body of research, the origins of sexual orientation are likely multifactorial and require further investigation.

Sexual behavior refers to the sexual activities in which an individual engages. What constitutes "sex" depends on whom you ask. Traditional definitions of "sex = intercourse" do not hold true for many groups, such as teenagers, women, and men who have sex with men (MSM), among others [24]. Does only penile-vaginal intercourse count as "sex"? What about oral and anal sex, mutual masturbation, and use of sex toys? Are these considered "sex" as well? When working from a continuum approach, we should be as specific as possible when inquiring about our patient's sexual orientation and behaviors while taking an open, nonjudgmental stance, so that every patient feels comfortable answering us honestly.

Sexual identity, or how a person labels their sexuality, represents an amalgam of one's sexual feelings, fantasies, attractions, behaviors, and romantic relationships. Sexual identity is one of the many dimensions of an individual's identity, or sense of self—who one is and how one fits into society. In contrast to more visible realms of identity, such as age, gender, race, and ethnicity, *sexual identity*, like spiritual and religious affiliation, socioeconomic status, and occupation, is largely invisible. Many theorists, including Erik Erikson, Sigmund Freud, and Vivienne Cass, have written extensively on the topic of sexual identity and proposed an array of stage models [24].

Within Erikson's psychosocial theory of development, the stages of adolescence and young adulthood bring important challenges in developing a core sense of personal and social identity and achieving intimacy or "genuine mutuality and love" [25]. According to Cass (1979), who set the standard for homosexual identity development, sexual identity is a universal developmental process that unfolds in a predetermined sequence through six stages: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis [26]. Though stage models allow us to better conceptualize and categorize human experience, there have been a number of critiques with regard to their universality, applicability, accuracy, and ability to capture the unique features and range of diversity found within real-life experience [24].

In light of these critiques, Savin-Williams [24] proposed utilizing a "differential developmental trajectories" framework to better reflect the diverse, unpredictable, and ever-changing lives of contemporary, same-sex attracted teens. Within this framework, Savin-Williams lays out four basic tenets:

1. Similarities: Same-sex attracted teenagers are similar to all other adolescents in their developmental trajectories. All are subject to the same biological, psychological, and social influences. He warns against exclusively focusing on sexuality as it runs the danger of misattributing normal adolescent experiences to sexual orientation.
2. Differences: Same-sex attracted teenagers are dissimilar from heterosexual adolescents in their developmental trajectories. Perhaps due to unique, biologically mediated constitution and cultural *heterocentrism* (negativity toward sex-atypical behavior, temperament, and interests), same-sex attracted young people's psychological development is different from that of heterosexuals.

3. Heterogeneity: Same-sex attracted teenagers vary among themselves in their developmental trajectories, and this can be similar to the ways in which heterosexual teens vary among themselves. The interaction of sexuality with gender, ethnicity, geography, socioeconomic status, and cohort results in distinctive trajectories among teens.
4. Uniqueness: The developmental trajectory of a given person is similar to that of no other person who has ever lived. Given the profound diversity inherent in individual lives, general descriptions of group-mean differences and similarities may be irrelevant when applied to a specific individual.

Although it is likely that there are more similarities than there are differences in the developmental trajectories of gender and sexual minorities as compared to the general population, there are some key areas of difference that are important to keep in mind when working with people on the gender and sexual continuum. The first is that many gender and sexual minorities recall "feeling different" from their peers beginning around 7 or 8 years of age. Often, this feeling is a result of gender-"atypical" or gender-"nonconforming" behavior. As many as two-thirds of adult gay men and women recall some gender-atypical behaviors or preferences as children [13]. In the United States, "tomboys," or girls who prefer boys' toys, games, clothing, and playmates, tend to have fewer problems with social adaptation than "sissy boys," or boys who prefer girls' toys, activities, dress, and playmates, as evidenced by our socially constructed labels for these two subsets of children [3].

Notably, children who display gender role behaviors that are more typical for the opposite sex will sometimes come to the attention of their parents, peers, or communities for violations of typical gender role behaviors. Gender identity and gender role behaviors often align, but not always. Many children with cross-gendered behaviors impactful enough to qualify for a diagnosis of gender identity disorder grow up to have persistent gender-nonconforming identities, but a vast majority of those children as they grow will no longer identify with the gender of the opposite sex of which they were born. Interestingly, a majority of these children with gender identity disorder (as defined by the DSM-IV) will later in life identify as being gay, lesbian, or bisexual [27, 28].

Another unique aspect of the developmental trajectory for sexual minorities is the process of *coming out*. Coming out involves becoming aware of and acknowledging one's own sexual identity (coming out to oneself) and disclosing that identity to others (coming out to others). It is a lifelong process that parallels one's development throughout the lifecycle. During childhood and adolescence, *coming out* might mean having a first same-sex crush, feeling different, or asking oneself, "Am I gay?" Later in adolescence or during young adulthood, *coming out* includes first same-sex intimate experiences, relationships, and telling friends and/or family. Although every individual uniquely identifies on the sexuality continuum, those who identify as a sexual minority must make decisions every day about whether or not to disclose their sexual identity, particularly during times of major life change, such as moving to a new town or starting a new school or job [3]. Younger generations seem to be coming out at earlier ages and often feel no need to label themselves at all. Older generations, who came of age during more conservative times, may have gotten married to opposite sex partners, had children, and begun the process of *coming out* much later in life. There is likely a similar but somewhat different process of coming out for gender minorities. The process may start earlier in life during childhood or adolescence and may be complicated by the need to make important decisions about puberty suppression in conjunction with their legal guardians and medical and mental health providers.

The Group for the Advancement of Psychiatry's online LGBT Mental Health Syllabus serves as a rich resource in exploring the unique issues facing same-sex couples and individuals through adulthood, including variations in intimate relationships, civil unions and marriage, parenting, and aging [3]. Although the US Supreme Court ruled in 2015 that the

Defense of Marriage Act (DOMA) and its restriction of the federal recognition and definition of "marriage" to only include opposite-sex couples was unconstitutional, the variability of nondiscrimination policies within individual states continues to obscure the rights of same-sex couples and perpetuates systematic discrimination against the LGBT community [29]. Despite barriers to reducing anti-LGBT rhetoric societally, the legalization of same-sex marriage had a significant impact on the visibility and normalization of sexual minority identities in the United States. Notably, the Youth Risk Behavior Surveillance System (YRBSS) sampled more than 700,000 high-school students and found a significant decrease in the rate of suicide attempts among sexual minorities living in states with policies recognizing same-sex marriages [30]. The American Academy of Pediatrics (AAP), American Medical Association (AMA), American Psychological Association (APA), American Psychiatric Association (APA), and National Association of Social Workers (NASW), among other professional organizations, explicitly support and recognize the positive impact policies that support same-sex marriage have on the rights, benefits, and long-term security of children in the United States [31].

Assessment

Assessment Overview Within a Biopsychosociocultural Framework

At all ages and in every culture, every person has a gender identity, and as cognitive and physical development progresses, every person develops a sexual orientation as well. The details, meaning, and impact of those identities can fluctuate over time, and there is a great deal of evidence to suggest that sexual orientation and gender identity are on a spectrum. However, if we are not able to sensitively ask the questions, our patients will never provide us with the answers that can help inform a comprehensive treatment plan targeted to each patient's individual needs. A thorough and thoughtful assessment can capture the specifics for each individual and help to avoid the unfortunate experience of bias that many LGBTQ patients face in their medical care. But before an assessment can be completed, a person must first seek care.

Because of accrediting organizations, enthusiastic students, trainees, and faculty as well as in response to the pressure from LGBTQ rights organizations, most training programs include some form of training on sexual and gender minorities. Yet despite the increase in training, LGBTQ individuals continue to experience significant bias in their doctor's offices. In a recent large national survey of transgender individuals, 24% of all respondents were denied equal care at a doctor's office or hospital and nearly 19% of respondents were denied care altogether. In addition, over one-quarter of respondents were verbally harassed at their doctor's office. Not surprisingly, those surveyed were less likely to seek care in part because of a legitimate fear of harassment [32].

Much can be done to set the scene prior to the healthcare professional even meeting the patient to reduce a person's fear of bias or discrimination. Review your intake documents and electronic medical records from the viewpoint of an LGBTQ individual. How does a transgender man identify gender when given only the option of male or female? How do same-sex parents differentiate themselves when given the option of mother or father? When a person has legal documents identifying them as one gender but they identify as the other, how do you ensure their preferred name and pronouns are used? Are there gender-neutral bathrooms available for use? Are there questions about sexual orientation in the documents, and are they asked in such a way that allow for the large spectrum of responses? For many patients and families, an early opportunity to create an environment that is respectful and affirming of the needs of LGBTQ patients is with front-desk staff. Training front-desk staff about the unique healthcare needs and barriers of LGBTQ patients and families can improve the extent to which institutions provide responsive healthcare experiences consistently. *Affirmative Care for Transgender and Gender Non-*

Conforming People: Best Practices for Front-line Health Care Staff is a valuable training resource developed by the National LGBT Health Education Center [33]. By giving LGBTQ patients and families a space for their identities to be acknowledged, you are already improving their care and potentially alleviating fears of possible bias and discrimination. When meeting the patient for an initial assessment, it is vital not to make assumptions and to stress confidentiality. A curious stance with open-ended questions is recommended to allow patients the flexibility to answer honestly about their gender and sexual development. It can be tremendously helpful to display materials that identify you as someone comfortable speaking with sexual or gender minorities, or alternatively, it can be helpful to normalize a wide range of identities and behaviors. Often, questions are directed either at identity or at behavior, but not at both. Identity does not equal behavior, and a person telling you they are heterosexual in no way completely defines their sexual behaviors or fantasies. Only by asking about identity and behavior as well as the meaning of both will you start to get a clearer picture of your patient's internal sense of gender identity and sexual orientation. Literature suggests that neither sexual orientation nor gender identity is a choice and that there are clear biological influences on the development of sexual orientation and gender identity. For example, twin studies investigating homosexuality [34, 35] showed higher rates of concordance among monozygotic twins (52% for gay men, 48% for lesbians) than for dizygotic twins (22% for gay men, 16% for lesbians) and for adoptive siblings (11% for gay men, 6% for lesbians), thus making a clear argument for a strong heritable component of homosexuality. However, how one expresses those identities does involve a degree of volition and is influenced by one's psychological, social, and cultural influences. This is as true for identities considered more normative than for identities less typically a part of the norm.

The process of "coming out" is primarily an experience thought to be limited to those with variations in their gender expression or sexual orientation, but everyone proceeds through identity development around their sexuality and gender, and often exploratory behaviors and thoughts in youth are not reflected by later identity consolidation in adulthood. Regardless if one identifies as gay, straight, bisexual or asexual, *cis-gendered*, *transgendered*, or *genderqueer*, at a certain point, a sexual orientation and gender identity are established, and frequently those early exploratory thoughts, fantasies, or experiences are forgotten. In one study, men reported same-sex experience rates of approximately 3% for the past year and 7–9% since puberty, and for women, approximately 1% in the past year and 4% since puberty [36]. These numbers reflect sexual behavior only and do nothing to quantify identity or fantasies, nor are these numbers predictive of later identity. They capture behaviors but miss out on the fuller picture of the diversity of gender and sexual expression.

As a society, we are much more comfortable with identifying folks on opposing poles than as on a spectrum. This stressor becomes very clear in work with bisexual or gender-queer individuals, those who choose to identify on a place on the gender and sexuality spectrum that places them apart from the current norm. By identifying in such a way that may be more internally consistent but less societally sanctioned, people are exposed to more bias and discrimination [37]. Those identifying as somewhere in the middle between gay and straight, man or woman, are often the most misunderstood, and a good assessment is the first step to understanding.

By thinking in a continuum approach, you are not limited to rubrics based on one identity or another. Every person, no matter their orientation or behavior, has biopsychosocial and cultural influences that define and modulate their gender and their sexuality. As such, age-appropriate assessment of psychosexual development should be done for every patient, and ideally, any assessment would be structured such that the provider can better understand the role that these biopsychosocial and cultural influences have played in their patients' lives.

There is not good data on the prevalence of gender variance, with most of the data coming either from the specialized gender clinics or patients presenting for cross-hormone treatment or sexual reassignment surgery. Numbers range from approximately 1 in 1000 to 1 in 20,000 individuals [38, 39], and these numbers do not account for those individuals that have an identity that fits somewhere along the gender spectrum that do not seek any treatment.

Psychologically, one must understand how one integrates their gender and sexual orientation into their identity. Have they fully formed their identity? Does it align with their behaviors? Does it bring pride, shame, or indifference? What is the impact of their identity and behavior on their mental health (substance use, depression, suicidal ideation) or in their relationships—romantic, sexual, or otherwise? Often those with gender-nonconforming identities or behaviors or those with same-sex interests are forced to keep their identities and experiences a secret—from their peers, from their families, and even from themselves. How does holding on to that secret impact their development and their functioning? There is no evidence to suggest that LGBTQ individuals use any separate defense mechanisms to address their challenges [40]. However, for those with sexual identity and/or gender identity that is not safe to be expressed, they often miss out on developmental experiences they see their peers engage in.

Socially and culturally, inquiries can lead into multiple social milieus. For example, what are the family beliefs about sex, gender, and sexuality? What are the community and/or religious views about gender and sexuality? Does the patient face bias? Is he or she safe to express his or her identity? What are the cultural values and mores of the social group? Do you know people that are going through a similar developmental trajectory? Asking these types of questions will help a provider to understand the context through which his or her patient conceptualizes their gender and sexuality and helps to later guide the treatment plan.

Comorbid Medical and Psychiatric Concerns

From the LGBT Mental Health Syllabus [3]:

> [Those living on the gender and sexual continuum] are people first and foremost, with the same primary care issues and needs as others across the lifecycle. [This] community is highly diverse, and any discussion of health risks and behaviors runs the risk of overgeneralization or even stereotyping, leading to questionable assumptions.

Our knowledge base with regard to medical and mental health concerns facing gender and sexual minorities is limited by two key factors:

1. There have been significant methodological challenges in conducting research on a group that is subject to bias and discrimination, both within society and within the medical system.
2. Until recently, those living on the gender and sexual continuum have not been included or adequately identified and characterized within important population health-based studies.

That being said, what follows is a review of key health issues to consider in your work with all patients on the continuum keeping in mind that risk is conferred by gene–environment interactions and behavior and not by sexual orientation or gender identity. It is important to ask about specific sexual and health-related practices, such as how often they see their healthcare providers, level of trust in the medical system, and willingness to follow-up with recommended screenings or treatments, to accurately assess medical and mental health risks in our clients.

Cancer

Though definitive studies are lacking, preliminary data suggests that sexual and gender minorities have a heightened risk for certain cancers. More research is needed to understand the natural history of disease in these populations. MSM have higher rates of non-Hodgkin lymphoma and

Kaposi's sarcoma associated with HIV/AIDS infection. Evidence increasingly suggests that MSM are at increased risk for anal cancer due to increased rates of human papillomavirus (HPV) and, as of yet, lack of standardized screening in this population. HIV-positive MSM should have yearly anal PAP tests, and those who are HIV negative should be screened every 2–3 years. The HPV vaccine is under study for the MSM population. Because the risk for HPV and anal cancer travels with sexual behavior and not sexual orientation, it is important to also inquire about current and historical sexual practices while working with all of your patients and not just those who are self-identified homosexuals.

Though no definitive studies have been completed, lesbians may be at higher risk of breast cancer than heterosexual women due to higher rates of risk factors, such as obesity, alcohol consumption, nulliparity, and lower rates of breast cancer screening. Lesbians also tend to receive less frequent gynecologic care than heterosexual women and might also be at higher risk for greater morbidity and mortality from gynecologic cancers, such as uterine and ovarian cancer. Women who have had sex with women (WSW) should be screened with PAP and for HPV as per the established recommendations for all women and vaccinated against HPV when appropriate [3, 41].

HIV/AIDS

The human immunodeficiency virus (HIV) is the infectious agent that can lead to acquired immune deficiency syndrome, or AIDS. HIV is spread through direct contact with an infected person's blood, semen, vaginal secretions, and breast milk. The HIV/AIDS epidemic has had enormous impact on global health, and patterns of transmission vary greatly between countries. In 2011, an estimated 34.2 million people worldwide were living with HIV, and there were 2.4 million new cases of HIV infections in 2011 alone [42]. Worldwide, unprotected sexual contact between people of the opposite sex accounts for more cases than those for same-sex contacts. However in the United States, MSM have been the largest subpopulation affected. Although the popular image of a person with HIV/AIDS is of a White gay man, African Americans account for 46% of those living with HIV with Latinos accounting for 18% and Whites accounting for 35%. New HIV infection rates remain disproportionally high among younger African American and Latino MSM [43].

Since AIDS was first recognized in 1981, we have made great strides in the prevention of HIV transmission and in HIV/AIDS care. The Center for Disease Control (CDC) estimates that 1.1 million people in the United States are living with HIV infection and that approximately 1 in 5 (21%) of those people are unaware of their infection [42]. With the advent of highly active antiretroviral treatments (HAART), what was once a nearly certain fatal disease has become a chronic disease for those who have access to treatment [3]. The availability of HAART not only increases the lifespan of those with HIV infection but also lowers some people's perception of risk and thus their behavior around unprotected sex and needle sharing. The long-term sequela of HAART, such as high cholesterol, diabetes, and the redistribution of body fat, need to be monitored closely by primary care, medical specialist, and mental health professionals.

The health implications of HIV are far-reaching and range from life-threatening opportunistic infections and malignancies to mental health challenges. Although significant medical advancements have improved the treatment of HIV in the United States, access to preventative care continues to be complicated and challenging for members of the LGBT community. Oral pre-exposure prohylaxis (PrEP) is a once-daily pill that can significantly reduce an HIV-negative person's risk of getting HIV through common high-risk exposures, such as sexual activity or injection drug use. Despite its efficacy and approval by the Centers for Disease Control (CDC), US Food and Drug Administration (FDA), and US Public Health Service, few healthcare providers are appropriately trained in screening for PrEP eligibility. Improving access to services across the HIV care and prevention continumm requires training medical and mental health professionals to screen and counsel all patients on safer sexual practices and appropriate adherence to preventitive medications [44, 45]. Those reporting higher-risk behavior, such as multiple partners, unprotected sex, needle sharing, or sex with partners who are sharing needles, should be screened more frequently, approximately every 3–6 months [3]. Professionals may erroneously assume that lesbians have had no history of sexual contact with men. In one study, 77% of self-identified lesbians had one or more male sexual partners in their lifetime. WSW appear to have higher rates of unprotected sex when having sex with men, more sexual contact with MSM, and more sexual contact with IV drug users when compared with exclusively heterosexual women [43]. These statistics demonstrate the importance of screening WSW for HIV along with women who are not sexual minorities.

Other Sexually Transmitted Diseases and Hepatitis

Because STDs and the behaviors associated with acquiring them increase the likelihood of acquiring and transmitting HIV, it is important that all patients be screened and counseled on safer sex practices and other preventative measures. Some surveillance data suggests that rates for syphilis and gonorrhea may be increasing among MSM. The current recommendation is that MSM should be screened yearly for gonorrhea, syphilis, chlamydia, herpes, HPV-associated genital and anal warts, and HIV. MSM are also at increased risk for proctitis, pharyngitis, and prostatitis, which are infection and inflammation of the rectum, throat, and prostate, respectively [41]. In terms of risk for lesbians and WSW, there have been confirmed cases of transmission of herpes, HPV-associated anal and genital warts, bacterial vaginosis, and trichomoniasis. Despite these risks, lesbians and WSW are screened and counseled on safer sex practices less frequently than exclusively heterosexual women by their healthcare providers [41].

The most common types of viral hepatitis, or inflammation of the liver, are hepatitis A, B, and C. All three of these unrelated viruses can produce an acute illness characterized by nausea, malaise, abdominal pain, and jaundice. Many persons infected with hepatitis B or C, which are transmitted through contact with an infected person’s blood or body fluid, are unaware they are infected. Both hepatitis B and C viruses can produce chronic infections that often remain clinically silent for decades while increasing risk for liver disease and liver cancer [46]. Vaccines are available for hepatitis A and B. Due to an elevated risk for hepatitis A and B in MSM, all MSM should be adequately vaccinated though many are not.

Mental Health and Substance Abuse

Gender and sexual minorities have higher prevalence of depression, anxiety, substance use disorders, suicidal ideation, and posttraumatic stress disorder. Some researchers hypothesize that the cause of the higher prevalence of these disorders is partially attributable to societal stigma, prejudice, and discrimination against gender and sexual minorities, which in turn leads to stress and mental health problems. This hypothesis, the *minority stress theory*, will be discussed in further detail in the next section. In the few larger-scale, national epidemiologic studies, suicidal ideation and attempt rates approach or exceed 50% and 20%, respectively. Recent studies of sexual minority youth populations continue to report alarmingly high rates of suicidal ideation and attempts at 3–7 times higher prevalence as compared with heterosexual youth [42]. However, some research demonstrates that gender diverse youth whose identities are supported experience comparable rates of psychopathology to their cisgender peers, and parental rejection may be an essential predictor of psychological functioning in adulthood [47]. With regard to substance use, gender and sexual minorities have higher rates of tobacco use, which is associated with increased risk for heart disease, lung cancer and emphysema, and a variety of other health problems. Studies indicate that gender and sexual minorities have higher rates of alcohol and illicit drug use. All patients should be routinely screened for alcohol and substance use disorders, especially since use is associated with other high-risk behaviors and negatively affects other chronic diseases. Clinicians should be familiar with some illicit drugs used more frequently among gay men, such as inhalants, hallucinogens, and the “club drugs,” such as ketamine, MDMA (ecstasy, Molly), methamphetamine (crystal meth), and GHB. A few studies have included lesbians and have found higher rates of tobacco, marijuana, cocaine, and alcohol use as compared to heterosexual women [3, 42].

Minority Stress Theory: Prejudice, Social Stress, and Health

Ilan H. Meyer and others have written extensively on the topic of *minority stress* as a possible explanation for why gender and sexual minorities have higher prevalences of mental health problems, substance use, and perhaps medical morbidity and mortality as well. In psychology, stressors are defined as events and conditions, such as the death of a loved one, job loss, or new illness diagnosis, that cause change and require that an individual adapt to a new life circumstance or situation. These situations include social conditions, which strongly impact the lives of those belonging to stigmatized social groups. According to Meyer and other stress researchers:

Prejudice and discrimination related to low socioeconomic status, racism, sexism, or homophobia—much like the changes precipitated by personal life events that are common to all people—can induce changes that require adaptation and can therefore be conceptualized as stressful [48].

The minority stress framework describes four underlying stress processes: (1) experience of prejudice events (discrimination), (2) expectations of rejection (stigma), (3) hiding and concealing, (4) internalized homophobia, and ameliorative coping processes. These stress processes can be described along a continuum from distal stressors, which are usually objective events and conditions, to proximal personal processes defined as subjective because they rely on individual perceptions and appraisals [48].

Starting with distal effects, studies have shown that gender and sexual minorities are disproportionally exposed to prejudice events, including discrimination and violence. For example, LGB adults are twice as likely as heterosexual people to have experienced a life event related to prejudice, such as being fired from a job. Furthermore, 20–25% of lesbians and gays have experienced victimization, including physical and sexual assault, robbery, and property crime. School-based studies suggest that gender and sexual minority youth are much more likely to be victimized by antigay prejudice events than heterosexual peers and that the psychological impact of these events can lead to severe negative developmental outcomes.

Stigma, or a mark of shame or disgrace, placed upon gender and sexual minorities by society leads to expectations of rejection and discrimination within the minority group [48]. These minority groups learn to become “constantly on guard” or vigilant that others that they come across in daily life might be prejudiced against them. Moving more proximally to the self, those living on the continuum often have to conceal their stigmatized identity to avoid negative reactions from others. However, there is a psychological cost to concealment as one’s energies and cognitive processes become disproportionately consumed and siphoned to this end. There have been many studies describing the adverse psychological, health, and job-related outcomes due to workplace fear of discrimination and concealment around sexual minorities. Although experiences of discrimination and societal stigma negatively impact the psychological well-being of all minority groups, a growing body of research suggests that social support and perceived acceptance may be protective against the aforementioned risks. Furthermore, sexual and gender minorities who are supported in the expression of their identities experience developmentally normative distress and psychopathology, and the literature shows that expressing emotions and sharing important aspects of one's self with others—through confessions and disclosures in meaningful relationships—are important factors in maintaining physical and mental health [49].

Internalized homophobia, or the internalization of societal antigay attitudes, within lesbians, bisexuals, and gay men, represents what Meyer describes as a form of stress that is "internal and insidious." Research has shown that internalized homophobia correlates with depression and anxiety symptoms, substance use disorders, and suicidal ideation. Studies also suggest an association with self-harm, eating disorders, HIV risk-taking behaviors, and difficulties with intimate relationships and sexual functioning [48].

Those living on the gender and sexual continuum also have access to powerful coping and resilience resources, such as opportunities for group solidarity and cohesiveness. Gender and sexual minorities have created stigma-free, empowering environments that foster growth and integration of one's gender and sexual identity with other important aspects of one's life. These environments and relationships allow for a reappraisal of the stressful condition, yielding it less power to negatively impact upon psychological well-being [48].

Multiple Minorities

Within each of us, we hold multiple identities. Gender and sexual identity are just two among many possible realms of self-definition and affiliation, including those based upon socioeconomic status, geographic region, race and ethnicity, religious and spiritual affiliation, and others. Furthermore, within each of these groups, there is significant heterogeneity. Those who hold multiple minority status may face unique struggles and simultaneously have access to alternative social support networks and resources. For example, LGB people of color can face alienation and discrimination by the LGB community and from their racial and ethnic community of origin, which sometimes leads individuals to feel forced to choose one identity over the other [3]. Individuals with multiple minority status (i.e., a lesbian, Latina female or an Asian-American, transgendered man) can also connect with others from similarly diverse backgrounds to create opportunities for social support and further integration of their complex identities. Religious and spiritual affiliations and institutions can also play a powerful role in one's acceptance or rejection of same-sex attraction, behavior, and identity. Men and women have very different experiences of living on the gender and sexual continuum based upon the unique developmental trajectories and socialization patterns and expectations for boys/men and girls/women within our society [3]. Other important realms to consider in your work are the effects of socioeconomic status, disability, and geography on the identity of those living on the gender and sexual continuum.

Case BA: Assessment

After seeing BA for the initial evaluation, treatment focused on anxiety and panic attacks, and BA was able to successfully attend high school. After a month of school, they reported continued anxiety that was a function of feeling intensely uncomfortable within their body. Through open-ended questioning by the clinician, BA disclosed that they identify as agender and not as a female. During subsequent sessions, an assessment of gender and sexual development was undertaken. BA reported that they never felt female, and when in elementary school and middle school, they did not see this as an issue. BA identified that going through puberty and growing larger breasts made them feel "less like themselves." They reported that they did not ever experience any sexual attraction toward others, though reported enjoying masturbation. They reported romantic feelings toward individuals who present as feminine but denied any sexual attraction to any gender.

Case SL: Assessment

Seeing SL for the initial evaluation, a full assessment of gender and sexual development was undertaken in addition to psychiatric functioning. SL reported that, for as long as he can remember, he felt uncomfortable conforming to "typical girly things." Throughout elementary school, SL described feeling drawn to male peers and became passionate about games and activities that made him feel "strong like the boys," including karate, violent video games, and sports. SL experienced significant rejection by male peers throughout childhood, which he speculates was a result of his insistence on wearing dresses and pink clothing to "compensate" for the discomfort he felt socially in gendered social contexts. SL began experiencing significant symptoms of social anxiety around age 11 and started isolating himself to avoid discomfort with female peers and rejection by male peers. SL described first learning about transgender identities and gender nonconformity through the Internet at age 12 and recalls writing in his diary, "I don't think I'm totally a girl." SL began exploring his gender identity in secret, referring to himself using typically male names in the mirror, taking photos with his hair tucked into a hat, and participating in message boards with trans-individuals online. SL's willingness to begin sharing the more masculine aspects of his identity changed after experiencing his first period at age 13, which led to overwhelming distress associated with his anatomy. Since age 13, SL described feeling "nauseated" by the round shape of his face, large breasts, vagina, high-pitch voice, lack of body/facial hair, and noted feelings of disgust associated with his capacity to bear children. Around age 14, SL described beginning to engage in NSSIBs to alleviate feelings of hopelessness and negative thoughts about his body that impaired his sleep and ability to focus during classes. SL did not disclose his anatomical dysphoria or gender identity questioning until he entered his first romantic relationship at age 16. SL began dating a transgender female peer who shared her experience transitioning socially and initiating hormone therapy. SL explained that exploring his sexuality and gender expression with a supportive partner helped normalize his preference for gender and sexual fluidity, leading him to come out to his parents and a few close friends at school. SL noted continuing to explore his gender and sexual identity and described himself as "mostly a boy and mostly attracted to feminine people."

Treatment

Treatment Overview

There is not a treatment for heterosexuality. Nor is there a treatment for homosexuality or bisexuality or gender variance. The scientific literature suggests that while one can, to some degree, alter one's behavioral patterns around sexual orientation and gender identity, it is not possible to change an enduring pattern or homosexual or gender-variant development [50–52]. Attempts to change one's sexual orientation through therapy (at times known as "conversion therapy" or "reparative therapy") have been practiced nearly as long as therapy has existed; however, there is little evidence to support its efficacy. Anecdotal reports that speak to its efficacy are counterbalanced by anecdotal reports that speak to its lasting psychological harm. One of the more controversial papers on the subject, "Can Some Gay Men and Lesbians Change Their Sexual Orientation? 200 Participants Reporting a Change from Homosexual to Heterosexual Orientation" [53], argued that reparative therapy may be effective for a small group of individuals wishing to change their sexual orientation. However, in 2011, Spitzer retracted his claim, reporting "in retrospect, I have to admit I think the critiques are largely correct… The findings can be considered evidence for what those who have undergone ex-gay therapy say about it, but nothing more" (http://prospect.org/article/my-so-called-ex-gay-life). The potential risks of this type of "therapy" include depression, anxiety, self-destructive behavior, and the reinforcement of the belief that sexual attraction toward the member of the same sex or a gender identity that doesn't match one's biological sex is pathological. The American Psychiatric Association, the American Psychological Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the National Association of Social Workers all refer to the practice of reparative therapy as substandard and/or unethical care. So if changing one's sexual orientation or gender identity is not a valid goal for treatment, what are appropriate goals and special considerations for treatment of LGBTQ patients?

Recognition of Similarities

First of all, it is important to note that there can be more commonalities in treatment planning for a bipolar gay man versus a bipolar straight woman than there are between a gay man with social phobia and a gay man with schizophrenia. A thorough assessment and diagnostic evaluation should first and foremost guide the treatment planning. Standard, evidenced-based interventions should be put into place for any primary psychiatric disorders. However, in working with the LGBTQ population, context is important. It is important to know the cultural norms, as well as the individual norms for the patient you are treating. For example, sexual expression and the frequency of sexual encounters can change based on the norms of the culture the patient identifies with. How does a treatment provider recognize the manic symptom of hypersexuality in the case of an asexual patient versus in a patient who routinely has multiple sex partners each week?

Identification and Management of Psychiatric and Medical Comorbidities

As described earlier in the chapter, LGBTQ individuals have an increased risk for a number of psychiatric and medical comorbidities. The culturally sensitive provider will learn how to assess for these comorbidities and apply evidence-based practices to address them. A mental health professional need not identify as LGBTQ in order to provide a treatment environment free of bias; however, some LGBTQ patients will specifically request having a provider with more personal understanding of what it means to be LGBTQ. It is the responsibility of the provider to help connect their patients to other culturally sensitive providers in order to reduce the risk of further healthcare discrimination. It is important to be aware of professional and community resources that can provide safe, supportive environments for LGBTQ individuals.

Identification and Management of High-Risk Behaviors

As described earlier in the chapter, LGBTQ individuals are more likely to be the victims of bullying or systematic discrimination and more likely to contemplate as well as attempt suicide. Data in this realm can be quite terrifying. Up to 40% of transgendered adults have attempted suicide at least once in their lives [32]. Researchers have begun to investigate risk factors and demographics of those more likely to attempt suicide in addition to investigating resiliency factors that are protective. Treatment in many ways is guided by this research. A stable sense of identity and a connection to a family/community that is supportive are two resiliency factors that have been identified as protective for suicide risk in youth populations [54, 55]. As such, the treatment provider has an opportunity to provide a safe space for a patient to explore their own identity free from judgment or free from agenda. In this way, the therapist can “protect the individual’s full capacity for integrated identity formation and adaptive functioning” [56]. For children and adolescents, the presence of an interested adult is protective against suicide for lesbian, gay, and bisexual youth, and the therapist can both fill that role and help their patients connect to community supports. Family interventions, particularly when working with children and adolescents are vital to help build family connectedness and mutual understanding of the patient’s exploration of their gender and sexuality.

Understand and Intervene on Stigma and Bias

It is the job of the healthcare professional to understand the societal and cultural context by which their patient may be exposed to stigma and bias and to help address and/or manage the psychological impact. In some schools and workplace environments, people are openly targeted for appearing gay, lesbian, or gender variant. Although Title VII of the Civil Rights Act of 1964 protects employees from being fired based on their race, religion, national origin, or sex, LGBT identities are not explicitly protected by Title VII in the eyes of the federal government. Numerous unsuccessful attempts have been made to update the terms of Title VII, but for the majority of LGBT employees in the United States, protection from discrimination in the workplace varies by state, county, or even city.

It is not explicitly stated that LGBT employees can be protected from termination based on their identities. As such, LGBTQ individuals often have to hide their identities at work or at school in order to protect themselves. As providers we have the opportunity to educate potential allies in these stigmatizing environments and help to build a safer environment for our LGBTQ patients. In addition, Medicaid policy dictates that no coverage be provided for treatment related to gender identity-related concerns, nor do many other insurers. As such, a two-tier system is created for gender-variant individuals—those that can afford the life-saving treatment and those who cannot.

Special Considerations for Gender Variance

The World Professional Association for Transgender Health is an international, multidisciplinary professional association with a "goal to promote evidenced-based care, education, research, advocacy, public policy and respect in transgender health" (http://www.wpath.org/about_mission.cfm). As a part of their mandate, they publish the Standards of Care for the Health of Transsexual, Transgendered, and Gender Non-Conforming People. The overall goal of the Standards of Care (SOC) "is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender-nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment." The SOC provides guidelines for mental health and medical professionals providing care for gender-variant individuals and seeks to establish evidenced-based practices. They recommend that mental health clinicians working with gender-variant individuals should have basic competence in mental health assessments and treatments in addition to a knowledge of the range of gender-nonconforming identities and expressions and of the assessment and treatment of gender dysphoria. Ongoing education and supervision in the field is vital to maintaining sensitivity and efficacy.

As for any person, a good treatment begins with a thorough assessment. Assessment of gender-variant individuals "includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers…" [57]. As described earlier, gender-variant behaviors are more common in childhood than in adulthood, and most children meeting criteria for gender identity disorder in childhood will no longer meet qualifications for that diagnosis as adults [58]. As such, it is important for the clinician to be "aware of current evidence on the natural course of gender discordance and associated psychopathology in children and adolescents…" [56] as well as in adults.

The health professional should provide education to their patients regarding options for gender identity expression and medical interventions and be able to assess for eligibility, preparation, and referral for hormone therapy and surgery. At present, the SOC recommends that if a patient is to begin puberty suppression or hormone treatment (i.e., estrogen for a biological male with a female gender identity or testosterone for a biological female with male gender identity), a qualified mental health professional must first assess the patient and provide a letter that identifies the patient's personal and treatment history, progress, and eligibility. An understanding of the risks, benefits, and alternatives must be demonstrated and the treatment options reviewed. It is a similar process for either breast reduction/removal or augmentation surgeries. For genital assignment surgeries, two separate qualified mental health professionals must provide support. Hormone treatment and surgery can be lifesaving, and the literature suggests that relief from gender dysphoria cannot be achieved without a closer congruence between one's gender identity and their primary/secondary sex characteristics [59–61].

Psychotherapy is not an absolute requirement for these referrals, nor is there one specific type of therapy that is recommended. The goals of therapy for gender-variant individuals are not manifestly different from anyone else—to maximize well-being, self-fulfillment, and quality of life. However, supporting a patient (as well as their family and community) through a gender transition is a unique task, and providers working with transgender clients should have experience with this process. For example, the mental health professionals must educate themselves about the processes for changing one's identity documents, advocacy options, and peer supports within the gender-variant community.

While there are unique aspects to treatment of the LGBTQ population, the process of treatment is no different. Every person develops a sense of their gender and their sexuality, and every person is profoundly influenced by these processes. To bring gender and sexuality into the treatment is to better understand and enrich the therapeutic relationship and encourage an open dialogue about identity that will have reaching impact beyond the realm of gender and sexuality.

Case BA: Treatment Follow-Up

BA engaged in weekly psychotherapy to address symptoms of panic disorder without agoraphobia, generalized anxiety disorder, and gender dysphoria in adolescence. The first stage of treatment focused on anxiety symptoms as BA did not report gender dysphoria until a few months into treatment. After helping BA manage anxiety better at home and at school, treatment focused on education regarding gender identity development. Given BA's strong and persistent agender identification, it was recommended that BA socially transition. The clinician worked with BA on finding a safe chest binder and in facilitating conversations between BA and their parents around their gender identity. The clinician and BA also collaboratively worked with BA's school alerting teachers to BA's preferred name and pronouns. This social transition improved BA's ability to engage effectively in school. They reported improvements in mood and anxiety in the classroom and felt affirmed in their gender identity with teachers and peers. BA continues to struggle with dysphoria related to their breasts and is considering a breast reduction or chest masculinization when they graduate from high school. They are not interested in hormone therapies and report that they feel affirmed in their gender through the use of gender-neutral pronouns from their family, friends, providers, and school personnel.

Case SL: Treatment Follow-Up

SL began weekly therapy with a new mental health provider to address the impact of gender dysphoria on the mental health challenges and risks impacting his ability to access hormone therapy. SL's treatment initially focused on improving coping skills to reduce the severity of life-threatening NSSIBs and rehearsing social skills to address symptoms of social anxiety impairing his capacity to appropriately elicit social support. SL began to report improved social functioning at school and increased perceived support following participation in an LGBTQ+ support group in his community. After a few months of reduced symptoms of anxiety and depression, treatment began to focus on clarifying goals for social and medical transition. The mental health provider collaborated with SL and his parents to advocate for use of his preferred name and pronouns at school and participated in family sessions to prepare for sharing his gender identity with extended family members. As a result of social transition across settings, SL began to report reduced feelings of shame and hopelessness and the family participated in an initial consultation at a local clinic to receive information about the risks, benefits, and realistic expectations for initiating hormone therapy. As SL's parents assented to hormone treatment and his mental health provider determined that his mental health was stable and reasonably well-managed, SL began receiving weekly injections of testosterone. After several months of hormone therapy, SL continues to experience significant anatomical dysphoria related to his breasts and genitalia and noted an increase in social anxiety in response to people commenting on noticeable changes to his body/facial hair and voice tone. Although SL still struggles with accepting his gender identity and presentation without surgical intervention, he continues to cope effectively with urges to engage in self-harm and is working with his mental health provider to develop an appropriate treatment team when he begins college.

Summary

Gender and sexuality exist in continuums with infinite possibilities. The gender and sexuality continuums are separate yet interrelated realms. The gender continuum can be further expanded into separate but not mutually exclusive masculine and feminine continuums. Consolidated gender and sexual identity develops across the lifecycle as a result of the continual integration of gender- and sexuality-specific realms of attraction/orientation, behavior/expression, and identity. Each individual is unique and composed of multiple identities that exist within and interact with other sociocultural realms, such as socioeconomic status, geographic region, race and ethnicity, religious and spiritual affiliation, and gender and sexuality, among others.

In order to provide the most effective, comprehensive, and appropriate care for our patients, we must be able to respectfully inquire about *all* of these realms for *all* of our patients. Research to date has shown that by building our level of skill, knowledge, and comfort in asking about these aspects of our patients' lives, we can improve overall health outcomes and strengthen our therapeutic alliances. Future directions for clinical work, research, and education are vast and include but are not limited to ensuring equal access to and improved quality of care for those living on the gender and sexual continuums as well as addressing the roots of stigma, discrimination, and prejudice both within healthcare and society at large.

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13

Understanding the Mental Health of Refugees: Trauma, Stress, and the Cultural Context

B. Heidi Ellis, Jeffrey P. Winer, Kate Murray, and Colleen Barrett

Introduction

Global forced displacement remains at unprecedented levels [1]. At the end of 2016, there were a record-high 65.6 million people forcibly displaced, according to the United Nations High Commissioner for Refugees (UNHCR) [1]. With 300,000 new people displaced in 2016, there were 20 people newly displaced every minute of 2016. Most refugees flee their homes with little time to prepare [2] and, in turn, frequently are ill-equipped with the financial, linguistic, and other resources needed to address the challenges of the journey that lies ahead. The nature of the pre-migration and flight experiences for refugees, which are frequently marked by fear, forced departure, and experiences of torture and trauma, distinguishes them from other voluntary migrants. Since 1975 approximately 3 million individuals have been resettled in the USA across all 50 states (approximately 2 million adults and 1 million children) [3]; this represents a significant population to respond to clinically [4]. Importantly, status as a forcibly displaced person seeking refuge is not in itself a psychiatric condition—refugee status is a sociopolitical phenomenon with common downstream psychosocial effects [5]. As refugees resettle in third-party countries, often after prolonged stays in refugee camps in a country or countries outside of their home, many experience mental health problems associated with past trauma, ongoing stress, or both. In order to effectively serve this population, mental health professionals including researchers, clinicians, educators, and policy makers will need to understand the impact of the refugee experience and cultural context on psychological functioning. This chapter will review the unique mental health challenges of refugees and culturally adapted assessments and treatments targeting some of the world's most vulnerable, yet resilient, populations.

According to Article 1 of the United Nations 1951 Convention on the status of refugees, refugees are persons who have crossed an international boundary because they are unable or unwilling to avail themselves of the protection of their former country due to a well-founded fear of persecution based on race, religion, nationality, membership of a particular social group, or political opinion. Refugees are distinguished from other forcibly displaced migrant popula-

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Table 13.1 Definitions according to UNHCR 2018 global trends document

Refugees	Individuals recognized by the 1951 Convention definition as persons who have crossed an international boundary because they are unable or unwilling to avail themselves of the protection of their former country due to a well-founded fear of persecution based on race, religion, nationality, membership of a particular social group, or political opinion
Asylum seekers	Individuals who have applied for international protection but their refugee status claims have not been verified
Internally displaced persons	Individuals who have been forcibly displaced but have not crossed an international boundary. The UNHCR provides protection and/or assistance to conflict-generated displaced persons
Persons of concern	Individuals who do not fall into the previous categories but to whom the UNHCR provides protection and/or assistance based on humanitarian or other special grounds

tions including individuals who are internally displaced within their native country, asylum seekers, or other persons of concern who have not yet been recognized by international bodies as refugees (Table 13.1). The UNHCR was established in 1951 with the mission of coordinating international efforts for the protection of refugees [6]. The UNHCR identifies three durable solutions for refugees: (1) returning to their country of origin once safety has been established; (2) integration into the country of first asylum, which is often a country neighboring the country of origin and where many refugee camps are established; or (3) resettlement in a third country. Less than 1% of all refugees are resettled (option 3) in any given year, with the largest numbers resettling in one of the nine most common resettlement countries (in alphabetical order): Australia, Canada, Denmark, Finland, the Netherlands, New Zealand, Norway, Sweden, and the USA [7].

In 2017, refugees from nearly 70 countries of origin were resettled globally across 34 countries around the world [8]. The largest numbers of resettled refugees engaged in UNHCR programs came originally from the Syrian Arab Republic, the Democratic Republic of the Congo, Myanmar, and Iraq. Across these distinct geographies and cultures, all are contexts where intractable conflict, oppression, and violence are present. The countries of asylum in which the most refugees left from include Turkey, Lebanon, Jordan, Nepal, and Kenya [8]. The UNHCR projected global resettlement needs for 2018 are 1.2 million people [8]. For the most up-to-date statistics on refugee resettlement trends, visit www.unhcr.org.

While recognizing that the largest burden of supporting forcibly displaced persons around the globe falls upon less economically developed countries, the USA represents the largest refugee resettlement program in the world (e.g., in 2016, the USA received 66% of UNHCR's refugee referrals) [8]. Together, the USA, Australia, and Canada resettle 90% of the global refugees within the refugee resettlement scheme [7]. The considerable number of refugees in the USA demonstrates that this is an important population for researchers, clinicians, educators, and policy makers to recognize and to be prepared to appropriately address.

Over the course of history, the refugee resettlement process in the USA has been characterized by waves of different ethnic groups. Initial refugee legislation in 1948 brought a wave of Eastern Europeans. Since that time the USA has welcomed populations from around the world including, but not limited to, groups originating from Hungary, Cambodia, Vietnam, Cuba, Russia, Somalia, the Democratic Republic of the Congo, Bosnia, Croatia, Sudan, Myanmar, Nepal, Bhutan, Iraq, and Syria. The process of resettlement provides a critical international tool for providing safety among the world's most vulnerable and at-risk populations. Although refugees arrive with varied ethno-cultural backgrounds and diverse experiences pre-resettlement, they share experiences of forced displacement, adjustment to a new country, a loss of resources and—for many—a history of trauma and/or torture. In addition to these common experiences, the constantly changing nature of geopolitical conflict leads to great cultural diversity among refugees; this incredible diversity of cultures within resettlement programs each year, and over time, poses a significant challenge for resettlement agencies, mental health providers, and host communities. Such cultural and ethnic diversity demands mental health services that are both cognizant of the common experiences and challenges of refugees while remaining sensitive, thoughtful, and responsive to the ways in which culture and history can shape experiences, symptoms, and attitudes toward and effectiveness of mental health interventions. As countries continue to resettle refugees from areas of political unrest and violence, questions of how best to support the mental health and adjustment of these populations will be critical.

Understanding the Refugee Experience: Trauma, Resettlement Stress, Isolation, and Acculturation

For many people from a refugee background, devastatingly violent wars and/or torture are defining features of their experience. Studies vary widely in the reported rates of torture and trauma among refugee populations, depending on the origin of the refugee group and the circumstances of their persecution and flight. One study of 353 refugees from multiple ethnic backgrounds in a Dutch refugee clinic found that 37% of individuals reported incidents of torture, 37% reported being close to death, and 35% stated that a friend or family member had been killed [9]. Another study found that the proportion of refugees who had been subjected to torture varied from 5% to 30%, depending on ethnicity and how torture was defined [10, 11]. A study of Kosovar Albanian refugees documented that approximately 67% of refugees reported being deprived of water and food, 67% reported experiencing an active combat situation, and 62% reported being close to death [12].

Importantly, refugees are likely to have experienced not one but multiple potentially traumatic events. In a study conducted within an African refugee settlement camp, Somali refugees had experienced, on average, 12 separate traumatic event types and Rwandese refugees had experienced, on average, more than 8 traumatic events [13]. Though traumatic events experienced after resettlement are less well documented in the research literature, for some refugees, especially those resettled in low-resource and high-crime settings, exposure to trauma through neighborhood or domestic violence is an unfortunately common occurrence [14].

Refugee children and adolescents have also frequently been exposed to violence, deprivation, and at times, torture [15, 16]. Research with Somali adolescents suggests that, similar to adults, refugee adolescents have experienced repeated trauma exposure [17]. While the term “refugee mental health” has at times been used synonymously with “refugee trauma,” an overly narrow focus on trauma and its consequences misses important aspects of the refugee experience that have direct bearing on refugee health and well-being. While many refugees have experienced traumatic exposure, sometimes in the context of torture or widespread violence, other aspects of stress that accompany the resettlement process are also critical to understand in order to better serve refugee and forced migrant populations. Research suggests that in some cases, the stressors encountered in resettlement, such as social isolation and discrimination, are important predictors of mental health problems and may account for a larger percentage of mental health symptoms than trauma exposure in one’s country of origin [18, 19]. For example, in a study of Bosnian refugees, the strongest predictor of depressive symptoms was current social isolation, whereas past trauma history did not predict depressive symptoms in this clinical sample [18]. Experiences of discrimination are common among refugee communities [20] and may contribute to experiences of social isolation, rejection, and identity invalidation and have been found to be important predictors of both posttraumatic stress disorder (PTSD) and depression among resettled Somalis [18, 21]. Discrimination has also been found to predict PTSD among adult Iraqi refugees [22].

Acculturative stress also plays an important role in refugee mental health. Acculturative stress includes both the challenges of navigating a new country, such as learning a new language and cultural norms, and stress that occurs within a family system as parents and children adapt to their new home in different ways and often at different paces [23]. Conflicts between children and parents over cultural values, or new responsibilities that fall to a child such as translating important legal or educational documents or acting as an impromptu interpreter during a medical appointment, can all contribute to high levels of acculturative stress. Broadly, acculturation gaps between family members can disrupt previous family hierarchies, values, and communication practices. Here, again, research suggests that trauma is less primary in the etiology of mental health problems than acculturative stressors; in a study of 447 Southeast Asian refugees, post-migration stress associated with acculturative tasks was a stronger predictor of psychological health than pre-migration trauma and stress [24]. While acculturative stress may be particularly high for new arrivals, for many refugees, it remains high even years after resettlement. Importantly, the particular nature of acculturative stress may change or evolve over time. While the initial challenge of finding familiar foods to cook with or learning the transportation system may decrease with time, stress associated with concerns about one's children losing or changing their cultural identity and practices may intensify over time. In addition to the culture-specific stressors of acculturation, a number of additional stressors of resettlement that are not unique to refugees, but that refugees ubiquitously experience, are also important predictors of mental health. Access to basic resources such as housing, jobs, and transportation is a key challenge faced upon resettlement and can play an important role in adjustment and well-being.

Taken together the research points toward the importance of broadening the lens through which refugee mental health is understood from a focus on *refugee trauma* to an emphasis on *refugee core stressors*, which include trauma, resettlement stress, acculturative stress, and isolation/discrimination. These core stressors may have a multiplicative effect in that the experience of trauma pre-migration may be particularly difficult to recover from in the context of the ongoing stressors of acculturation, resettlement, and isolation [25]. The authors have summarized the four core stressors below; further information on these stressors and the ways in which they guide assessment and treatment planning is available through the Refugee Trauma and Resilience Centerwebsite at https://is.gd/Corestressortool.

Mental Health Needs

In part because of the high rates of trauma exposure and significant stressors during resettlement, individuals and families with refugee backgrounds are at risk for elevated psychological distress. Much of the research on refugee mental health focuses on trauma-related outcomes, such as rates of PTSD [26–28]. Prevalence estimates of psychological disorders vary widely and are likely influenced by both the methods used to assess prevalence (e.g., survey vs. diagnostic interview) and cultural differences in symptoms and openness to reporting symptoms [27].

Most estimates suggest rates of PTSD are higher in refugee compared to non-refugee populations. One meta-analytic study calculated prevalence rates of 9% for PTSD among refugee adults and 11% for PTSD among refugee children, which places refugees at roughly *ten times* the risk for PTSD than their age-matched counterparts [26]. Other studies suggest prevalence rates range from 4% to 44%, with larger and more rigorously designed studies identifying an average of 9% prevalence for PTSD [26]. Refugee adults were also at elevated risk for major depressive disorder (MDD), with rates ranging from 2% to 18% across studies with an average rate of 5% across studies with more than 200 participants. A systematic review of 181 studies of adults who had experienced conflict and displacement showed a weighted prevalence of more than 30% for both PTSD and depression [29]. In a meta-analytic study that included over 16,000 refugees, researchers found prevalence rates that ranged from 4.4% to 86% for PTSD, 2.3% to 80% for depression, and 20.3% to 88%

for anxiety in war-exposed refugee adults [30]. Across the studies examined in this meta-analysis (29 in total), clinical prevalence rates were almost always 20% and higher. While these large prevalence ranges make population-based estimates difficult, we can confidently say that rates of stress-related psychiatric illness among refugees are much higher than that of their non-refugee peers [27].

Research has largely indicated a dose–response effect of psychological distress among refugee and forced migrant communities; with increasing levels of exposure to torture and trauma, there are associated increased symptoms of psychological distress [31]. The extent of perceived life threat has been linked to the magnitude of symptoms of anxiety and PTSD [32, 33]. Furthermore, research indicates individuals with more than one diagnosis (e.g., PTSD and MDD) have worse prognosis in resettlement [34].

Increasingly, attention has been drawn to the suicide rate among refugees after resettlement. Since 2007, more than 56,000 Bhutanese refugees have resettled in the USA, and in early 2009, increasing numbers of suicides in this population were being reported. By February 2012, 16 suicides among Bhutanese refugees in the USA were confirmed, which translates to a rate of 20.3/100,000 and is comparable to the rate of 20.76/100,000 that was confirmed from an assessment done in refugee camps in Nepal [34–38]. These figures are notably higher (e.g., almost double) than the USA rate of 12.4/100,000 [39]. There is some evidence that the presence of trauma and/or PTSD is associated with an increased risk of suicide among refugees [40, 41]. Bhui and colleagues [42] investigated trauma history among refugees and found that suicidal ideation was more common among those who experienced pre-migration shortage of food and serious injury and those who felt close to death. Within a study of Bhutanese refugees resettled in the USA, those who had experienced their house or shelter being burned down prior to resettlement were four times more likely to report suicidal ideation [35]. Ferrada-Noli et al. [40] found a high incident rate of suicide attempts (40%) in refugees with a PTSD diagnosis. Whether refugees in general are at an elevated risk for suicide, or whether some refugee groups are at decreased risk for suicide due to cultural or religious taboos, is not yet fully understood. However, given the high rates observed among Bhutanese refugees, suicidality is an important area to assess and consider within refugee mental health.

In addition to trauma- and stress-related outcomes, refugees may also experience other mental health disorders at higher rates than non-refugee populations. In children, higher rates of autism have been noted among children of Somali refugees [43]. In adults, rates of schizophrenia appear to be higher among refugees than nonmigrants [44]. Among children, Fazel et al. [28] identified two studies of psychotic illnesses in which 2% of 226 adult refugees were diagnosed with a psychotic illness. While elevated rates for numerous disorders have been identified within the literature, the limitations of existing tools in terms of cultural validity and available norms must be acknowledged. We discuss these issues in further detail later in the chapter.

The prognosis of mental health problems over the course of resettlement is quite variable. Several studies have shown that the prevalence of mental health problems drops significantly over time following resettlement [45, 46]. However, other studies have found that elevated mental health symptoms may remain for decades following resettlement [46–48]. Steel and colleagues [49] found that psychological disorders dissipated over time for the most part, but for a subset of highly traumatized individuals, the risk for psychological distress remained high for up to a decade after resettlement. This finding suggests the importance for more prospective research designs that are better able to determine different trajectories of adaptation over the years following resettlement. Moreover, research that examines resilient responses to trauma and adversity will help advance interventions and programs that promote health and successful adaptation among those that are struggling with mental health and other adaptation challenges.

Experiences in resettlement vary widely for different age groups, genders, and cultural groups; in turn, some are at greater risk for poor mental health outcomes. In general, being older or female has been associated with worse outcomes in resettlement [27, 50, 51]. In addition, refugees from rural backgrounds, those with higher levels of education, and those with higher pre-displacement socioeconomic status (SES) are more likely to report worse outcomes [27]. While the finding that higher pre-migration SES and education are associated with worse outcomes may appear counterintuitive, the loss of resources has been identified as particularly detrimental to recovery from trauma [28]. Individuals with higher status and greater material resources before migration must contend with a dramatic change in these resources (e.g., a former physician now working as a hospital custodian), representing a loss of interdependence and past aspirations. The experience of loss (e.g., loss of family members, culture, and ways of life) also demonstrates a unique contribution to reports of trauma symptoms as well as loss distress [52]. Thus, the experience of loss (both traumatic and non-traumatic loss) is an important factor that predicts psychological distress in refugee populations.

Mental Health Needs of Child and Adolescent Refugees

Prevalence estimates of mental health problems among refugee children and adolescents vary widely. Estimates suggest that between 10% and 69% develop trauma-related mental health problems [53, 54]. Other studies of refugee children have also documented elevated rates of other disorders, such as depression, anxiety, somatic complaints, sleep problems, and behavioral problems [15].

As with refugee adults, outcomes over time can vary; a study of Cambodian adolescents followed into adulthood documented that depressive symptoms diminished significantly over time, but that PTSD symptoms remained elevated even 12 years after resettlement [55]. Among refugee youth, the nature of psychosocial problems may change over time; youth resettled for a longer period of time may become more vulnerable to substance use, gang involvement, and other conduct problems. This finding may seem counterintuitive, that maladaptive outcomes increase across resettlement, but as youth acculturate to the USA (e.g., learn English, learn adolescent cultural norms), they are more likely to engage in both the adaptive and maladaptive social behaviors that impact youth who grow up in the USA.

Among children and adolescents, individual, family, and contextual factors are all important in supporting mental health outcomes [16, 56, 57]. At the individual level, exposure to violence, physical, psychological, or developmental disorders, time since displacement, sex, and level of education can influence outcomes. Families play a central role in the lives of refugee children; families often flee in part to protect their children from violence in their home countries. Parents and families continue to serve as what has been called the child's "protective shield"—buffering children from the world of stress around them. Yet for many refugee parents, the challenges of navigating a new culture, establishing a new life in a new country, and managing their own physical and mental health needs may make it difficult to provide the same kind of protection that they capably provided in their home countries. Unfamiliarity with language, culture, and school systems, their own trauma and related struggles, and the challenges of making a living in a new country can all limit parental capacity to protect and assist one's children. Some refugee children lose parents or other important family members through death or separation. The degree to which a refugee family remains intact and able to nurture children plays an important role in the child's mental health outcomes [33]. Thus many factors, above and beyond past trauma, influence child and adult refugee outcomes. These factors, and their relevance to mental health outcomes, suggest the importance of widening intervention targets beyond a trauma-only focus.

Resilience and Positive Responses to Forced Migration

While significant research has identified the understandable mental health needs common among refugees, there is a growing emphasis on promoting an understanding of positive adaptation and recovery from adversity and trauma. In general the prominent response to adversity and trauma is that of the capacity to sustain functioning and even to thrive [58, 59]. There are also instances where refugees may develop high levels of mental health symptoms *and* continue to function at very high levels [60]. There is a growing focus on research that examines well-being and adaptive outcomes [61] independent of pathology and distress. Papadopoulos [5] highlights that not only do people frequently survive horrific conditions largely intact but that they may also be strengthened by their experiences through adversity-activated development. This refers to the process in which exposure to adversity requires transformation and adaptation in order to effectively respond to the challenges at hand. While the capacity to cope with adversity may be universal, the specific manifestations of resilience may vary across cultures. This may include, for example, the relative importance of individual-level (e.g., self-efficacy) versus community-level (e.g., collective efficacy) resources [62]. Other theories of stress adaptation including the adaptive calibration model [63] may be applied to understand how some refugee individuals are profoundly resilient in the context of extreme adversity. The capacity for resilience and adaptation—through a variety of individual, familial, and community resources and processes—suggests that there is much to be learned from those who adapt and thrive despite adversity. With an overemphasis on examining pathology and distress, there is a missed opportunity to understand the breadth of human experience and the range of mental health outcomes experienced in resettlement.

Barriers to Care

Despite elevated levels of mental health distress, relatively few refugees access mental health services. In a national study of Asian American/Pacific Islanders, mental health services were utilized at 1/3 the rate of non-refugee Americans [64], and among refugee children and adolescents, as many as 92% of those in need do not access appropriate mental health services [65–67]. While mental health access rates are likely to vary by specific ethnic group and other demographic characteristics, the generally low use rates suggest that focused attention to service access among refugees is needed. Practical knowledge gained by refugee providers and partnerships with refugee communities, as well as the extant academic research, have highlighted key barriers to refugees receiving mental healthcare [29, 68]. Common barriers include (a) distrust of authority and/or systems, (b) stigma of mental health services, (c) linguistic barriers, and (d) primacy and prioritization of resettlement stressors. Mental health promotion among refugees requires an integrated response to these common barriers. Further work is needed to promote the cultural capabilities of existing services to be responsive to diverse populations within their practice. A wide range of factors influence access and quality of care for diverse populations, including the need for better training of providers [69] and addressing the systemic factors that readily contribute to health and healthcare disparities for underserved populations [70].

Distrust of Authority and/or Systems

The experience of refugees often includes extreme abuse of power by those in authority. Systems usually designed to protect people may have come under the power of those who perpetrated atrocities. Sharing personal information with strangers, such as one's tribal affiliation or even their full name, may have placed one at risk of being a target of violence. As a result, many refugees, especially those who have experienced government-sanctioned persecution and violence [71, 72], have developed an understandable distrust of authorities and governmental systems, and this distrust may be applied to healthcare service systems. Perception of individuals and institutions of power is also a central issue. Due to a history of marginalization and a legacy of disempowerment in social, political, and economic arenas, refugees may mistrust service providers who represent a more socially empowered group [73, 74]. Experiences of distrust and alienation likely only increase as the experience of being a refugee comes under greater international scrutiny and heated sociopolitical discourse. Issues of power and distrust may affect services at the individual level, challenging the development of a therapeutic alliance, or at a programmatic and community level, leading to low rates of engagement and high no-show rates. The potential legacy of distrust may require extra time for rapport building and development of a sense of safety and security during the process of treatment [75]. Programs that build trust not just with identified clients or patients but with whole communities may be better accepted when services are indicated. Healthcare systems' use of community health worker models is increasingly widespread as there is a growing recognition of the need for greater representation within the health sector and in the delivery of services.

Stigma of Mental Illness

The stigma of mental illness within many refugee communities may serve as a considerable barrier to seeking mental health services [76, 77]. In many cultures, mental illness is considered a taboo topic and is not openly discussed [77, 78]. For some ethnic groups, there are even limited words to describe mental health or mental illness in their language [76, 79]. In some refugee communities, mental illness is not understood on a continuum; an individual is either "well" or "crazy" [77, 80, 81]. Furthermore, recovery from mental illness may not be believed to be possible. When a youth exhibits internalizing or externalizing problems, refugee families may define the problem as an issue related to success at school or culture-specific conflicts within the family or community. A refugee or migrant individual who uses drugs or alcohol to cope with mental health problems may be seen as violating religious or cultural expectations and subsequently be ostracized from the community. In some instances, community members may be concerned that if an individual is known to be receiving mental healthcare, the stigma they may experience would be more damaging than receiving no care at all. More broadly, refugee and migrant communities may hold different explanatory models for psychological problems [80, 82] and view what mental health providers label as "mental illness" as problems related to spirits, possession, or religious events [76, 77, 83]. Overcoming such stigma requires thoughtful community-based dialogue with stakeholders and leaders, broad-based psychoeducation, and outreach efforts at the individual, family, and community level. Structural changes, such as delivering services within trusted agencies like schools, resettlement agencies, community centers, or places of worship, can further reduce potential barriers associated with the stigma of mental illness. The integration of cultural formulations into treatment and service delivery represents a critical and needed step that acknowledges the cultural bounds of current diagnostic systems and treatments within a specific Western psychiatric model of disease. The explanatory models framework [80] provides an approach that enables collaboration and discussion of the range of understandings of the etiology, course, and consequences of mental illness, including what constitutes culturally appropriate steps in addressing concerns.

Linguistic Factors

When a person from a refugee background does seek to engage in mental health services, the lack of linguistically accessible and culturally responsive services presents a further barrier [84].

Simply put, services must be available in the language of fluency of the patient and family in order to be accessible. Even if a child is fluent or proficient in English, parents may not be [85, 86]. This presents a challenge to obtaining parental consent for treatment for a child and subsequently engaging the parents in the child's treatment. Given the range of linguistic proficiency among refugee children and adults—and at times the preference for different languages between child and parent—services need to be flexibly available in different languages. Changing demographics of refugee arrivals further complicates the capacity of mental health and social service organizations to provide linguistically appropriate services. The use of interpreters, in person or via phone or videoconference, can aid in reducing this barrier. The use of children or relatives as interpreters is strongly discouraged. This is because children are placed in a dual role as family member and paraprofessional and are exposed to information that may not be appropriate or effective for them to hear in such a context. Even if a parent consents to such an arrangement, providers should make every effort to find another alternative and should be transparent about this with the family. In some programs, the integration of a cultural broker, or an individual trained to not only interpret the language but also interpret the culture and context of both the refugee's cultural group and the service system, has served to improve both linguistic access and culturally responsive practice [87, 88].

Primacy of Resettlement Stressors

Finally, even if barriers of trust, stigma, and language are addressed, many refugee individuals and families do not identify obtaining mental health services as a primary need. Rather, managing the resettlement stressors, such as ensuring adequate food and housing for the family and securing employment, is prioritized [89]. These foundational needs generally need be met or at least partially stabilized before most refugees have the practical and psychological resources available to focus on mental health treatment [86]. Research suggests that these ongoing stressors may be important determinants of refugee mental health and well-being [18, 90, 91]. Despite this, mental health service systems and refugee resettlement services are typically delivered by different agencies with relatively little integration and connection. Families referred to mental health services may look to providers for assistance with tangible needs such as food and housing and may be reluctant to spend time and energy engaging in services (e.g., talk-based psychotherapy) that do not directly and overtly address basic needs (e.g., completing housing application paperwork). Mental health services that broaden the scope of care to facilitate addressing multiple aspects of the social ecology that impact the individual are likely to be more successful in engaging refugees in mental health treatment. If providers do not have the resources or training to support other basic needs, it is important to consult and/or provide "warm handoffs" to other providers so that important issues do not get overlooked (e.g., attending an initial meeting with a housing-focused social worker or printing out and explaining directions to a local food pantry and then calling ahead to let the organization know a family is on their way).

Mental Health Assessment

Individuals with refugee backgrounds present a number of challenges to traditional psychological assessment, including validity of conducting assessments cross-culturally, complex physical and psychological issues that may be present with refugee trauma and torture survivors, and the broader social context that influences psychological well-being and suffering. These three assessment challenges are considered below.

Cross-Cultural Validity of Mental Health Assessments

Methodologically, many standardized mental health assessment tools used in mental health evaluations have not been specifically developed or adapted for use with refugees [29, 83, 92].

Instruments used with Western populations may not be available in the necessary languages and, even when they are, may not have been adequately tested for construct validity and linguistic comparability. Refugees from orally based cultures, in which the language is primarily spoken rather than written, or who are not fully literate in any language, may be unfamiliar with standard assessment formats, including commonly used Likert scales, rendering such tools much less useful. Established assessment norms or cut-off scores may be unavailable for a specific cultural group in question and therefore have no appropriate clinical reference point for quantitative assessment and tracking. Whereas psychological assessment with any population should take into account how social and cultural identity shapes the presentation and formulation of a mental health problem, over-medicalizing distress within refugee populations can be especially toxic and short-sighted because of the enormous social and ecological factors that likely influence the presenting problems [93, 94].

When possible, instruments that have demonstrated cross-cultural acceptability and validity with the population of interest should be used. Examples include trauma screeners such as the War Trauma Scale and the Harvard Trauma Questionnaire [95]. Examples of measures of psychological distress that have been adapted for refugee populations and the use of which has been documented in the literature include the Hopkins Symptom Checklist-25, the Beck Depression Inventory, the Impact of Event Scale, and the Posttraumatic Symptom Scale-30. Additionally some instruments, like the Harvard Trauma Questionnaire, have been validated in multiple different languages [96]. In the absence of culturally validated instruments, scoring and interpretation of assessment tools should be done in the context of other information that has been gathered and used to inform clinical judgment rather than determine diagnoses. For a more extensive list of measures that may be effective for use with refugee families, please visit https://www.nctsn.org/resources/refugee-standardized-measures.

Assessment in the Context of Complex Physical, Psychological, and Sociocultural Factors

Refugees, and in particular trauma and torture survivors, often present with complex physical and psychological factors that may affect assessment. As discussed in relation to treatment engagement, past experiences of abuse or mistreatment at the hands of authorities may significantly contribute to a reticence to trust and share personal information [97]. For some, a clinical interview may be reminiscent of past trauma, as in the case of torture survivors who underwent interrogations. Those who are seeking or have received asylum status may also be concerned about whether divulging information could be used to undermine their case and their safety. For these reasons, extra time and care may be needed to build and establish rapport and trust so that the information that needs to be broached can be discussed effectively. Head trauma including previously undiagnosed traumatic brain injuries, occurring in the context of torture, war, or flight, may further complicate assessment. Similarly, malnutrition or severe untreated illness histories may also contribute to short- or long-term cognitive deficits and may heavily influence the results and recommendations of psychological assessment [98]. Within some cultures, strong taboos or gender roles may also affect the degree to which refugees feel comfortable sharing information with providers. A female survivor of sexual violence, for example, may be particularly hesitant to share this information with a male provider due to her traumatic experiences as well as potential cultural stigma and shame associated with rape. Even if the clinician is female, the presence of a male interpreter or someone known from the community may impede open discussion. Awareness of gender norms, cultural taboos, and sensitivity to the changing dynamics when an interpreter is present are all important considerations when determining steps for culturally responsive and empathic assessment.

Assessment of the Broader Social Context and Protective Resources

In addition to standard domains of mental health evaluations, clinical assessment of refugees should include an assessment of the pre- and post-migration experiences that particularly impact mental health outcomes (e.g., the four core stressors; see Table 13.2). Fazel et al. [32] discuss specific pre- and post-migration factors that put refugee youth at risk for psychological difficulties or mental health issues. On an individual level, risk factors include exposure to pre-migration violence and exposure to post-migration violence. Risk factors on a family level include having a single parent, having a parent with psychiatric problems, having a parent who was exposed to violence, having poor financial support, and arriving in host country unaccompanied. On a community level, risk factors include perceived discrimination and several changes of residence in the host country. The multiplicity of factors that impact a refugee's well-being needs to be taken into consideration as part of a comprehensive assessment of psychological functioning.

Table 13.2 Four core refugee stressors

Traumatic stress	*Occurs when a person experiences an intense event that threatens or causes harm to their emotional and physical well-being. Refugees may experience traumatic stress related to:* War and persecution Torture Rape Forced displacement from home Flight and migration Poverty Starvation Family/community violence
Resettlement stress	*Is related to the refugee experience as people try to make a new life for themselves in a new country and may include:* Financial stressors Difficulties finding adequate housing Difficulties finding employment Loss of community support Lack of access to resources Transportation difficulties Loss of pre-migration status
Acculturation stress	*Occurs as people try to navigate between their new cultural context and their culture of origin and may include:* Conflicts between children and parents over new and old cultural values Concern over children "losing" their culture Conflicts related to cultural misunderstandings The necessity to translate for family members who are not fluent in English Problems trying to fit in at school Struggle to form an integrated identity including elements of their new culture and their culture of origin
Isolation stress	*Is related to refugees' experiences as ethnic and cultural minorities in a new country and may include:* Feelings of loneliness and loss of social support network Discrimination Experiences of harassment from peers or law enforcement Experiences with others who do not trust the refugee Feelings of not "fitting in" with others

Mental Health Interventions

There have been multiple reviews in the past decade that detail the current evidence base in refugee mental health interventions for adults and/or youth [15, 21, 27, 84, 99, 100]. These reviews have underscored the growing publication of refugee intervention research but also the limited numbers of tightly controlled trials [101]. For example, in a 2007 review of PTSD-specific treatment studies by the Institute of Medicine (IOM), only two studies with refugees [102, 103] met the criteria of well-designed studies to be included in the review. The challenges associated with conducting randomized controlled trials with refugee populations are significant, and innovative research designs and methods are needed to address this evidence gap [104].

The vast majority of evaluated interventions have focused on symptoms of anxiety and PTSD associated with trauma. Cognitive-behavioral therapy (CBT) has been the most commonly evaluated approach and treatment trials have largely demonstrated reductions in PTSD and anxiety symptoms [67, 84, 95, 102, 105, 106]. Studies have evaluated CBT with a wide range of populations such as Cambodian adults, either alone [107] or in combination with pharmacological interventions [67] and in school-based samples of youth of varying nationalities [84]. A recent systematic review and meta-analysis of 12 clinical trials found narrative exposure therapy, a trauma-focused variant of CBT, to have the best empirical support for treating PTSD in refugee and asylum seekers resettled in high-income countries [108].

In recent years the shift in focus from a long-standing emphasis on reactions to torture and trauma has researchers and practitioners questioning the cross-cultural applicability and utility of the traditional trauma treatment model [101, 102]. Increasingly there has been more of a focus on understanding refugees' experiences and challenges within the resettlement environment, which is more modifiable, and in fostering strength, capacity, and resilience among individuals and communities [5]. Researchers and practitioners are increasingly incorporating approaches that acknowledge cultural differences in meaning and distress and that foster culture-specific methods of coping and responding to adversity [109, 110]. There has been a growing emphasis on interpersonal [111] and narrative expressive therapy approaches [104, 112, 113], which correspond well within cultures with more collectivistic and oral traditions.

In working with refugee youth, the largest body of evidence has been in the evaluation of school-based programs [84, 107, 113, 114]. Many of these programs focus on the use of arts-based therapies to support the expression and resolution of trauma and adjustment-related concerns through a developmentally appropriate medium. Some adolescent refugee mental health programs have also focused on addressing social and environmental challenges faced by youth, such as stressors related to family conflict, unstable living conditions, and financial stressors [65, 109]. In the psychological- and systems-based intervention, Trauma Systems Therapy for Refugees, an adapted model of Trauma Systems Therapy [115], school-based psychological skill-building groups addressed acculturative stress and basic communication and emotion regulation skills, while more intensive, individualized trauma treatment was provided for youth with more significant mental health needs [21]. Programs such as this represent essential multilayered responses that not only recognize the importance of addressing trauma but also the need to target the resettlement challenges commonly faced by refugee communities that are frequently living in low-income and under-resourced neighborhoods. More such programs are needed that support the wide-ranging challenges associated with forced displacement and resettlement.

Regardless of the model of care used, knowledge of an individual's culture and refugee experience will better inform care. Below, the authors have created a table of key questions and issues that providers can consider across the provision of services when working with refugee communities.

Key Questions and Issues for Consideration When Working with Refugees

- What is this patient's country of origin? What is the recent history of that country and what led to the exodus of refugees?
- What are the patient's social and cultural identities (e.g., race, ethnicity, religious and spiritual beliefs, gender, disability status, etc.)? Within their country of origin, did their particular identities and status (e.g., ethnicity, religion/religious sect, tribe/caste) have unique experiences of power and/or persecution?
- How did the patient come to be here? Did this individual spend time in refugee camps, have a dangerous flight, and arrive as an asylum seeker? Did the patient arrive with other family members? If not, who are they separated from and what are the circumstances that led to the separation?
- How long has this individual lived in the USA? Has this individual migrated within the USA?
- How is mental illness viewed in their culture? How is psychological distress expressed?
- How is healing approached in their culture? Who or how does one turn to help in their culture? Is the patient seeking help through traditional means as ascribed by their culture of origin?
- What is the resettlement context for this patient? Is there a strong, supportive ethnic community that the patient is or could be a part of? Does the patient have support for basic resettlement needs, e.g., housing, job training, language classes?
- What is the preferred language(s) of the patient and what languages are spoken in their family? If needed, who will interpret for the patient? Does the interpreter come from a particular ethnic, tribal, or religious background that is different from the patients, and if so how might that affect the work?

Asking many of these questions directly to a patient or family member during the first session(s) is not recommended because trust has yet to be developed between the provider and patient. Some initial understanding of many of the above questions can be gained through online resources that include brief summaries of the culture, history, refugee experience, and health practices of refugee groups (e.g., Ethnomed.org; or UNHCR.org; http://www.cal.org/areas-of-impact/immigrant-refugee-integration). Although every refugee's experience is unique, being aware of the general sociopolitical context that has affected the client and their community will both communicate the clinician's interest in understanding the client's culture and also allow for a more nuanced understanding of the client's particular experiences. While a provider can never understand all the intricacies of the many refugee cultures that may resettle in their country, some basic knowledge can help guide questions in a manner that shows respect for the client and a willingness and empathic openness to learn. Imagine if your healthcare provider did not know some of the most basic information about your country or culture of origin—would you trust them or assume that they would be knowledgeable in helping you?

Psychopharmacology

Psychopharmacological interventions can be effective treatments for mental health problems for some refugees and may be more acceptable than psychotherapy within some cultural groups where receiving a medical intervention is seen as more socially acceptable than a psychotherapeutic intervention. There is a need for more research evaluating different pharmacological approaches for the treatment of refugee individuals, and this literature is even more sparse than the research on behavioral health interventions for refugees. In a 2017 review paper, 15 pharmacological intervention studies with refugees were reviewed, but due to limited power and inconsistent study designs, the authors reported that there is not yet evidence for formal psychopharmacological recommendations for treating depression and PTSD in refugee populations [116].

Of the limited available psychopharmacological evidence, Smajkic and colleagues [114] found significant reductions in PTSD and depression symptom severity and improvements in Global Assessment of Functioning (GAF) scores following 6-week treatment with sertraline (selective serotonin reuptake inhibitor, SSRI, antidepressant) and paroxetine (SSRI, antidepressant) in a trial with adult Bosnian refugees. Another treatment group was treated with venlafaxine (serotonin-norepinephrine reuptake inhibitor, SNRI, antidepressant) and evidenced significant reductions in PTSD symptom severity and improvements in GAF scores but had no changes in depression and reported significant side effects. Otto and colleagues [117] found the greatest improvements in a study of Cambodian refugees were those treated with combined sertraline and ten sessions of CBT.

As with other intervention approaches, it is important to consider how cultural attitudes and understanding of medication may affect medication adherence for diverse refugee populations [118]. Some individuals of refugee backgrounds may assume psychiatric medications function similarly to medications such as pain relievers, in that medication should be taken when symptoms are felt and are expected to lead to rapid and immediate symptom relief [117]. This perspective may lead some refugees to stop taking their medication if it does not work immediately and/or stop their medication as soon as symptoms reside. Rapid self-initiated changes in psychopharmacological medication dosing are not advised and can at times make existing problems worse. Ongoing monitoring and education around the reasons why psychiatric medication needs to be taken consistently may improve medication adherence and treatment buy-in. In addition, possible barriers to taking medication, such as concerns that fasting during Ramadan prohibits medication, concerns that Western medications are addictive, or preferences for traditional non-pharmaceutical remedies, should be reviewed in consultation with cultural brokers.

Additional Cultural Considerations

In considering effective and appropriate mental health services for refugee populations, there are a number of important additional cultural considerations. Culturally responsive practice with refugee and migrant communities requires a balance of cultural competence (i.e., the attitudes, knowledge, and skills to appropriately and effectively work with diverse populations) and cultural humility (i.e., an open, empathic, curious stance in which one can learn about others with the assumption that one will never be an "expert" in any culture) [119]. It requires recognition of the broader systems of power, privilege, and structural inequality [120], as well as the need for organizational, structural, and clinical levels of cultural responsivity and intervention [121]. Having a basic fund of knowledge about a refugee group, such as their country of origin's history and their reasons for fleeing [84, 88], along with an understanding of foundational cultural norms and traditions is important for effective practice. To do this, there are numerous resources available online to learn more about the culture and country of origin of individuals a clinician hopes to serve [96, 122]. There is also a significant need to enhance training programs and their effectiveness in preparing and upskilling practitioners in their cross-cultural capabilities. As mental health providers, it is critical to understand culture-specific explanations of and expressions of mental illness and psychological suffering (e.g., cultural idioms of distress), to recognize how they manifest within specific cultural contexts, and to effectively and appropriately respond to such presentations. Mental health services that explicitly integrate cultural training and consultation into their practice, and models of care that allow for flexible adaptation to different cultures, contribute to providing culturally responsive services for refugees.

In addition to building representation of diverse populations within the mental health profession, another way to increase culturally responsive services is through the use of interpreter services or cultural brokering [123, 124]. The use of these services can facilitate cross-cultural communication and improve quality of care in clinical settings. In some settings, the use of a professional cultural broker takes the place of an interpreter. The role of a cultural broker differs from that of an interpreter in that in addition to providing interpretation, the broker also serves as a bridge, link, or mediator between groups or persons of different cultural backgrounds for the purpose of reducing conflict and producing effective and sustainable change [125]. Cross-cultural communication includes both verbal and nonverbal communication, as well as the communication of cultural norms. Cultural brokers bi-directionally interpret both the spoken words and the subtext communicated through nonverbal and/or culture-specific communication. An example of this might be for the broker to interpret not only the spoken words of a client to a provider, "can I offer you some tea?", but also the subtext that to refuse the drink in someone's home would suggest distrust and disrespect. A cultural broker might also later share with the clinician that offering tea is a common sign of courtesy and respect and to refuse such a gesture, particularly as a person in a place of relative power is potentially offensive or insulting.

Many more complex and multifaceted concepts may require cultural broking, such as how to physically sit in a psychotherapy session (e.g., eye contact, foot placement), what experiential psychological interventions (e.g., role-playing, mindfulness exercises, exposure procedures, arts and crafts projects) are appropriate or inappropriate, a family's perception of symptom manifestation, how "talking" about problems can be effective, and so on. The role of cultural brokers in a mental health program is multifaceted; they act as an essential conduit between the patient and provider, hold and share information that facilitates the relationship between patient and provider, and act as a bridge upon which the relationship between the patient and provider is built and strengthened.

There are multiple considerations for using an interpreter or cultural broker in a clinical setting. It is important to provide these services when an individual or family speaks English as a second language or when there is a specific language/dialect that the family wishes to receive services in that the provider is not fluent in. As discussed earlier, providers should avoid using children or other family members as interpreters, and whenever possible use a consistent interpreter or cultural broker for continuity, establishment of trust, and building an effective working partnership between broker, clinician, and patient. Brokering or interpreting services is best delivered when the provider can set aside time prior to the session and ideally following the session to discuss content and goals of the session with the broker or interpreter. This discussion allows for mutual information sharing and feedback, dyadic strengthening, and effective treatment planning between the two professionals.

Conclusions and Future Directions

While the nature and location of political conflict around the world will continue to change, the need to welcome those who have been most affected by violence and human rights abuses remains certain. As the field of refugee mental health research and clinical innovation moves forward, improvements in the clinical assessment and diagnosis of refugees and forcibly displaced individuals will better enable mental health providers to effectively serve this population. Mental health providers, educators, and policy makers have an increasing opportunity to structure mental health services in ways that meet the complex challenges of refugee communities. Both organizational and systemic considerations, as well as clinical approaches, can build on recent refugee research to provide a comprehensive, integrated response to refugee mental health needs.

Organizational/Systemic

Increasingly, refugee mental health is being understood as an outgrowth of not only trauma but also the significant challenges faced by refugees in resettlement (e.g., acculturative stress, social isolation and discrimination, structural resettlement stressors). These various needs are not simply additive but interrelated; trauma treatment may be less effective for a refugee family struggling with basic living insecurities, and the ability to obtain employment may be especially challenging for refugees struggling with mental illness. Mental health services that are provided in an integrated fashion with other resettlement, health, and social services may be most successful in engaging, retaining, and effectively treating refugee and forcibly displaced communities. This could be accomplished through the integration of other services into mental health service systems or by delivering mental health services through service systems already serving refugees (e.g., resettlement centers, community centers, schools, places of worship). The authors note that in their intervention development and evaluation activities through the Refugee Trauma and Resilience Center at Boston Children's Hospital, building partnerships between community agencies, mental health providers, and other service systems such as resettlement agencies and schools has shown particular promise in meeting the multilevel needs of refugees.

Clinical Approaches

At a clinical level, the effective support and treatment of individuals with refugee backgrounds will be greatly aided by additional research on appropriate assessment tools for different ethnic groups and more rigorous intervention research. In addition, research on adaptive and resilient outcomes may shed further light on protective processes that can be facilitated or bolstered. While significant progress has been made in this field since the initiation of the first US-based resettlement programs in 1948, more efforts are greatly needed to enhance understanding of the impact of refugee stressors and optimal methods for intervention.

People from refugee backgrounds will continue to arrive from different countries, and the mental health service system must be prepared to flexibly respond to the linguistic and cultural characteristics of new refugee groups. There is a significant need to improve training models and the representation of diverse populations within the healthcare delivery system. Attention must also be paid to the ways in which organizational and structural factors may impede effective and culturally responsive care. Models such as integrating cultural brokers into mental health service systems provide a framework on how practices can be adapted and delivered to new groups. Although the specific adaptations and cultural considerations may change with each new group, the process of thoughtfully integrating cultural expertise into clinical treatment, in consultation with community stakeholders and leaders, should remain constant. In order to accomplish this, important future directions include establishing formal billing mechanisms so the work of cultural brokers is supported in a sustainable way, establishing clearer training and professional development guidelines for cultural brokers embedded within clinical and social service settings, and providing more formalized opportunities for mental health providers to become trained in refugee and immigrant responsive care.

While much work remains to be done in understanding the experiences, mental health trajectories and healing of refugees and forcibly displaced communities, providers, educators, researchers, and clinicians must be prepared to serve these individuals and families in need of mental health services. Together we must seek to address this need by shaping systems and services to be more accessible to those in need, by responding with culturally responsive and affirming practices, and by meeting the abuses wrought on humanity with dignity and hope.

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