# Diversity and Culture

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Sarah H. Arshad, Jaclyn Datar Chua,
Lauren P. Baker, and Cheryl S. Al-Mateen

**Key Points**

- The population of the United States is becoming more diverse.
- Healthcare disparities and poorer mental health outcomes are disproportionately faced by minorities and people from lower socioeconomic backgrounds.
- There continues to be stigma against seeking evaluation or treatment for mental healthcare.
- Understanding patients' cultural identities and backgrounds is paramount to conducting mental health evaluations and treating patients and families. Many transitional age youth continue to rely on their families for support.
- As children transition to adulthood, they are more likely to engage in abstract thinking and identity formation.
- Family and community influences may provide support and/or complications, which could contribute to either resilience or impairment in functioning. These may affect tasks otherwise expected of transitional age youth: gaining financial independence from parents, establishing longer-term relationships, and completing education requirements.
- Different cultural backgrounds can influence how well a youth is able to complete developmental tasks, how involved families expect to remain, and also provide different expectations for these youth.
- According to the Integrative Model of Racial Identity Development, people go through stages from conformity to integrative awareness, which are different for people of color than for White people.
- Intersectionality is a framework to consider how multiple identities interact. Patients should be conceptualized using

S. H. Arshad · J. D. Chua
The Children's Hospital of Philadelphia, Department of Child and Adolescent Psychiatry and Behavioral Sciences, Philadelphia, PA, USA
e-mail: arshads@chop.edu; chuaj1@chop.edu

L. P. Baker
Department of Psychiatry, Child and Adolescent Psychiatry, Virginia Treatment Center for Children, Virginia Commonwealth University Health System, Richmond, VA, USA
e-mail: lauren.p.baker@vcuhealth.org

C. S. Al-Mateen (✉)
Departments of Psychiatry and Pediatrics, Virginia Treatment Center for Children, Virginia Commonwealth University Health System, Richmond, VA, USA
e-mail: cheryl.al-mateen@vcuhealth.org


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this intersectional framework. Providers must consider how patients' cultural backgrounds affect their symptom presentation in ways specific to the patient's intersectional identity and avoid generalizations.
- Providers should consider acculturation and acculturative stress, especially with immigrants and refugees.
- There have been studies demonstrating implicit and explicit bias in healthcare providers. Bias can also affect health seeking behavior.
- The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) has an Outline for Cultural Formulation (OCF) and a Cultural Formulation Interview (CFI) which can help providers obtain important information to make a cultural formulation.

## Introduction

The US population is becoming more diverse, and racial and ethnic minorities are soon to collectively become the majority. US Census data predicts that, by 2020, more than half of the children in the nation will be from "minority" racial or ethnic backgrounds and that, by 2044, more than half of the US population will be comprised of minorities. By 2060, almost one in five, or 19%, of the US population will be foreign born [1]. Currently, minority groups and those from lower socioeconomic backgrounds bear the brunt of healthcare disparities in this country, increasing their morbidity and mortality [2]. Specifically, racial and ethnic minorities receive lower-quality healthcare, even when access-related factors are controlled [3]. Social determinants, defined as "the conditions in which people are born, grow, live, work, and age" [4], further divide "certain population subgroups [who] are at higher risk of mental disorders because of greater exposure and vulnerability to unfavorable social, economic, and environmental circumstances" [5] (p. 09). These social determinants of health must be considered when attempting to improve overall health and include socioeconomic status, the stability of family and community systems, immigration, and protective factors such as religiosity and social supports [5]. These determinants are not fully reviewed in this chapter, as they warrant a larger body of work in and of themselves, but are incorporated in the situations of the patients from the sample cases.

In addition to disparities, there continues to be significant discrimination and stigma against mental health care [6]. To help combat disparities, an Institute of Medicine (IOM) report recommends that healthcare professionals receive training in cultural communication [7] given that clinical providers may have a significant role in reducing discrimination and stigma [6]. Additionally, the American College of Physicians' (ACP) 2003 position paper exhorts that all patients, regardless of their cultural identities, deserve equitable, high-quality healthcare and also calls for cultural awareness and sensitivity among providers, a reduction in bias, and training in cultural competency [8]. Studies have demonstrated explicit and implicit bias among providers when considering their patients' personalities as well as patients' abilities to comply with treatment [9].

A patient's cultural background is important in the developmental process of identity formation. Understanding its impact is also vital in their mental health evaluation, treatment planning, and recovery. Providers are charged to practice "cultural competence" [10], which has been defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" [11] (p. 4). When transitional age youth begin to define themselves by prioritizing their multiple cultural identities, which can create a sense of solidarity with particular groups [12], it becomes especially important for providers to identify and inquire about these associations.

Cultural competence has broadened over time to include the conceptualization of "cultural humility" which adds acknowledgment that cul-

ture is not static [13]. It posits that understanding culture requires "a critical consciousness" by considering medical, social, and historical context [14]. In addition, intersectionality theory discusses the interplay between cultural factors and systems and how they can influence beliefs about health and illness [2]. Tools to obtain and conceptualize this information include the Cultural Formulation Interview (CFI) and the Outline for Cultural Formulation (OCF), both found in DSM-5 [15]. This chapter presents these concepts related to culture through clinical case examples of several transitional age youth (TAY).

## Cases

Case 1: Maaria, a 17-year-old young woman, currently a junior in high school, is referred by neurology for mental health consultation because she has had a worsening of chronic tension headaches now with migrainous features. She is from an Indian family (parents immigrated to the United States before she was born), and she has an older sister. The patient tells the mental health professional that her sister also "has issues" but that "no one talks about it." The parents are practicing Muslims (mom wears a hijab), but Maaria, who is not identifiably Muslim by her choice of clothing, privately says that she is "taking a break" from religion. She also says that she has experienced some bullying because her family is Muslim. The patient tells the mental health provider that she identifies as bisexual but would never discuss this with her parents. The patient endorses being "very depressed" with passive thoughts of death. When the patient's mother is interviewed, she describes herself as an "overbearing 'Desi' mom" and is most concerned about the patient's declining school performance.

Case 2: "Sam" (Samantha), a 17-year-old youth assigned female gender at birth presenting with depression, confides in the psychiatrist that he identifies as transgender male and that his family does not know. His depressive symptoms began about a year ago and have been getting progressively worse. He lives in a rural area, his father is employed as a construction worker, and his mother is a stay-at-home mom. The family's income intermittently dips below the poverty line, and they require public assistance to meet their basic needs. Sam is the eldest of four children (two brothers and one sister). Sam has been an above-average student, and his family was hoping he would go to college, which would make him the first in the family to achieve this. However, his dream is to pursue a music career full-time, without obtaining a higher education. His family belongs to a conservative Christian church, and he identifies as Christian but believes he would not be supported after his transition. Sam's family does know about his depression, and even though he thinks that medications and therapy would be helpful, the family shares that they will instead pray and turn to the church for help with Sam's depressive symptoms.

Case 3: "Lily" (Lilliana), a 22-year-old woman, presents to a therapist with symptoms of anhedonia, troubles with sleep, lower energy, and guilt. She has had transient periods of feeling sad in the past but has never sought treatment before. A college student majoring in accounting, she is in her final year of college with a 3.8 grade point average. It was a difficult decision for her to pursue higher education instead of working because she and her family are undocumented immigrants from Mexico. She was initially hopeful about being able to apply for citizenship, but this is no longer possible for her. She is persistently concerned about her family's real risk for deportation. She is also worried about her legal status impacting her ability to find a job after graduation. Moreover, she feels a responsibility to contribute to the family's finances. Her parents both work as day laborers, and she has three younger siblings, one of whom chose to work after high school completion to financially support the family. The younger two siblings are still in middle and high school, and they were born in the United States.

Case 4: Becca, a 20-year-old Caucasian woman from a middle-class family, presents to the emergency room with suicidal ideation. She identifies with her Jewish heritage and grew up going to her synagogue regularly and attending

camp for Jewish youth over the summers. She is enrolled in the local community college while holding a part-time job doing clerical work at her synagogue. She lives at home with her family and has a supportive friend group. She confides that in the past 6 months, she formed a romantic relationship with a woman but does not want to tell her family. Her fear of rejection, not only by her family but also by her community and peers, has led to increasing symptoms of depression and eventual thoughts that she would rather be dead. Neither Becca, nor anyone in her family, has previously sought mental health treatment.

Case 5: William, a 17-year-old African American cisgender heterosexual male, presents to his family doctor due to anxiety and frequent panic attacks. He has been mostly shy his whole life, preferring to stay inside and play video games. He has experienced mild to moderate heterogeneous anxiety since childhood, where he worried about his academic performance and the safety of his parents. His cognitive ruminations and occasional "nervous stomach" mostly were managed with intermittent supportive therapy. His recent-onset panic attacks began 3 months ago when he was a passenger during a police stop when his mother had a broken headlight. He had his first panic attack while in the car and continues to have recurrent panic episodes triggered by sirens and occasional loud noises (like the doorbell). He had no prior interactions with any law enforcement, but some of his family members were killed by gun violence (not police). He has stopped driving because he is afraid of recurrent panic attacks. His immediate family's socioeconomic status is middle class. Some of his uncles have substance use disorders and have temporarily experienced homelessness.

Case 6: Alice, a 19-year-old woman and an only child who currently lives with her parents, is referred for a mental health evaluation due to frequent tearfulness. Her family immigrated from Korea before she was born. Alice had plans to attend a local college after she graduated high school, but in her senior year, she was diagnosed with leukemia. She had to take a year off to complete chemotherapy treatment, including two bone marrow transplants. She had to lose her ear piercings due to the infection risk. She no longer fits into her previous clothing due to side effects from her medications, which caused her to lose weight overall, including her steroid regimen which changed her body composition. She used to take pride in her appearance and had hopes of becoming a social media influencer as a makeup artist and fashion icon. She no longer feels inspired to do this. Due to her compromised immune state, for 100 days after her bone marrow transplants, she had to remain in relative isolation, which she describes as a very lonely time. Her friends were supportive, but most of them went to college, while she had to stay behind. Her family also accumulated significant financial bills from her treatment as well as caring for her during that time – her parents missed work, parked at the hospital, bought meals, etc. She currently feels "stuck" and purposeless. She wants to apply for a job as well as continue to pursue college, but Alice's parents feel very uncomfortable with her having responsibilities outside of the house. They do not want her to consider living in the residence halls while at college due to fears about her health as well as concerns about the financial costs. They would prefer that she live at home.

Case 7: Jerome is an 18-year-old senior in high school raised in an affluent African American family who presents for a follow-up appointment with his mental health provider. He has sickle cell disease, and after his first hospitalization for acute chest syndrome when he was 14 years old, he also developed an initial adjustment disorder followed by major depressive disorder. He and his family were on board with mental health treatment, and his depression has been previously managed with intermittent therapy and medications. His parents have been slightly more lax in their academic expectations of Jerome because of his numerous hospitalizations for sickle cell crises despite following medical advice to prevent these, especially in his senior year. Both of his parents have doctoral degrees and have high educational expectations for their children. Jerome is the youngest child, with an older brother and sister, both of whom attend Ivy League universities. After his recent

birthday, Jerome told his parents he was not planning on attending college immediately but wanted to get involved in political grassroots organizations and social justice activities. His parents had not known he had already attended protests, or that there were a few times he had almost gotten hurt or arrested. They are very upset that he is not applying to college, and they also think he has been more irritable, angry, and depressed in the past year.

Case 8: Adenike is a 21-year-old woman with no past medical or psychiatric history who presents for possible first break of psychosis to the emergency room, and after a medical workup is normal, she is admitted to a psychiatric hospital. She is brought in by her Nigerian-born parents, who are currently going through a marital divorce. Her mom works in retail, and her dad works in the food service industry; both of their employers require strict attendance. This has made it very difficult for them to come to the hospital for daytime meetings with her primary treatment team. Her mom is very concerned that Adenike, who never used to be religious, has been praying more and has been conversing out loud to God. Her dad is adamant that, as a deeply faithful Christian, Adenike has always been devout. He thinks that these behaviors are within normal limits for her, the family, and their church. Adenike's dad believes prayer alone will help her to move forward. She is an only child, and the rest of their immediate family are in Nigeria. The family identifies a local Nigerian community as a source of support.

Case 9: Abraham is a 19-year-old Latinx cisgender man who presents for symptoms of feeling overwhelmed, difficulty getting out of bed, and intermittent stomachaches. His mom is from the Dominican Republic and his dad is from Puerto Rico. He is a middle child – his older brother received a football scholarship to attend college, and he had received some offers as well but opted to forego college. His two younger sisters are both still in middle and high school. He is working at a local electronics store while trying to teach himself graphic design. His parents are conservative Catholics, and while he enjoys some of the cultural traditions from his childhood, he does not believe in God. This has led to some discord between him and his family, and he just learned that his 18-year-old girlfriend is pregnant. He is not sure how he will tell his family, or how he will support his girlfriend and child.

## Developmental Considerations for Culture in the Transitional Age

As children transition through adolescence to young adulthood, they undergo evolutions in their thought process. Piaget describes formal operations as the beginning of abstract thinking as teens reason through moral and philosophical issues and thought becomes more logical [16]. Erikson describes adolescence as a time of searching for personal identity by exploring different values with the rise of independence. Youth in this stage begin to consider the place they will take in the "real world," whether it involves continuing education or starting a career, or leaving their parents' home [17]. Additionally, growing into the transitional age, relationships become more intimate (Fig. 21.1).

Through these developmental stages, youth are also "charged" to take ownership over their identities, including gender, race, ethnicity, religion, and sexual orientation, among others. This marks a shift from identity being largely informed by their family and community to increasingly self-selected. However, family and community influences remain factors that may both support and complicate the formation of the TAY's unique identity. As highlighted in many of the sample cases, TAY may wrestle with conflicts between family's culture and their own as it begins to take shape. For example, Maaria, Sam, and Becca each come from different religious and ethnic backgrounds but have similar concerns about family or community acceptance of their gender or sexual identities. There are also concerns about conflict as a consequence of their emerging identities, which could impact other aspects of their lives, including finances and housing (e.g., Maaria lives with her parents; Becca works for her synagogue).

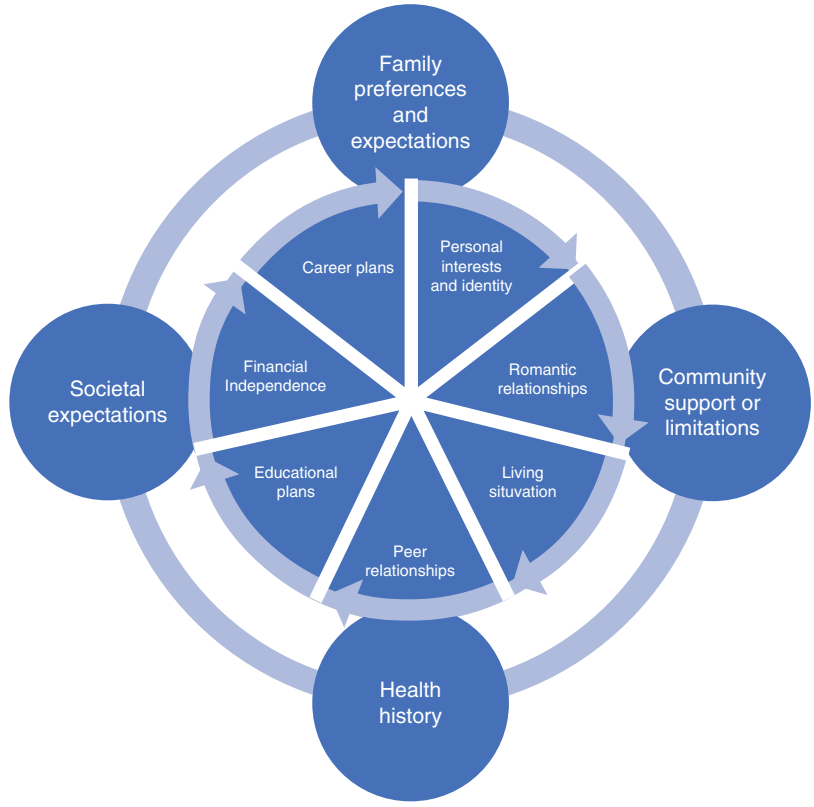


**Fig. 21.1** Interplay of personal aspects of TAY individuation and cultural or other factors

While some conflict is part of normal development, significant conflict may impact optimal functioning. A positive sense of ethnic-racial identity is associated with fewer depressive symptoms; internalizing, externalizing, and antisocial behaviors; less substance abuse; and less risky sexual attitudes [18]. It should be similarly considered that having a positive sense of identity also lends itself to psychosocial benefits. Connection with self-identified culture, overall parenting style, and parent response to individuation can also impact mental wellbeing during this time of transition, as highlighted in Fig. 21.2 [19]. Conversely, divergence of ideals between TAY and their parents can negatively impact mental health. One study of migrant families found an increase in suicide rate among female immigrants ages 18–25 years compared to other age groups, with adolescents in this group who took overdoses holding less traditional cultural views than their parents [20].

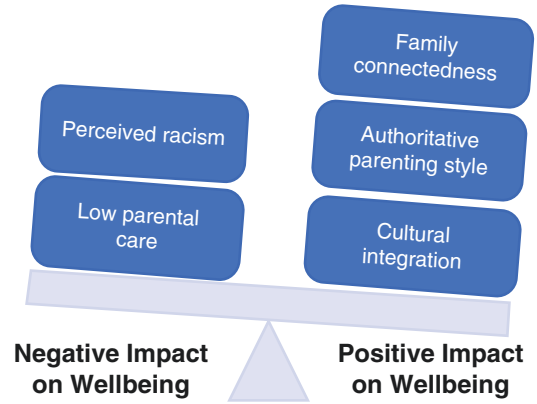


**Fig. 21.2** Summary of factors influencing mental wellbeing [19]

A positive sense of identity can provide better grounding as the emerging adult navigates the world with a growing host of responsibilities. Developmental tasks for transitional age youth ages 18–25 years include developing self-identity, emotional and financial independence from par-

ents, management of personal self-care, completion of educational requirements, and establishment of long-term relationships. This may be overwhelming for some TAY, particularly those with known psychiatric disorders [21]. From the cases above, Alice struggles with navigating independence from her family, and Becca is worried about complete financial independence. TAY must navigate whether to pursue higher education, vocational training, getting a job, or a combination thereof. In the case examples, Lily struggles with guilt over having chosen higher education instead of economic employment. Sam and Jerome, who are from very different backgrounds, both struggle with the parental expectation of higher education when they both would like to pursue other ambitions. Abraham is also struggling with establishing financial independence for himself, as well as for his pregnant girlfriend.

In addition, each TAY continues to pursue relationships, intimate and platonic, navigating these over the course of their otherwise changing lives and responsibilities. It is more difficult to predict demographic information (i.e., employment, student, relationship or health insurance status) within this group than in adolescents under 18 years or adults over 25 years. This highlights the great range of opportunities during this developmental stage with high levels of exploration and experimentation and particularly low constraints [22]. De Goede et al. [23] note that "the transition to a vocational career and entering into a satisfying intimate relationship are two important developmental tasks in the lives of youngsters" (p. 15) which are important for their mental health. Strides toward establishment of vocational and relational identity correlate with improved mental wellbeing.

Opportunities during this phase of life are broad and varied but may be restricted by cultural constructs. Cultural background and expectations can either bolster or limit a youth's perceived options [22]. Perceived discrimination, weak ethnic identity, low self-esteem, and increased conflict with family have all been associated with increased psychiatric symptoms and disorders [24]. There may also be different cultural pressures on TAY in different areas of their growing independence (e.g., pressure to pursue higher education over contributing to the family finances, to live independently or within families, to find romantic partners and pursue serious intimate relationships). From the case examples, Lily worries about contributing financially to her family although she is doing well in her last year of college, while Jerome's parents wish he would apply to college when he prefers to focus on social justice efforts. Abraham chooses to work and independently train himself in graphic design over attending college, and he will likely have increasing financial burdens coming soon with his expected child. Alice wants to work or attend school but is discouraged by her parents due to her recent medical problems. Maaria's mom seems to downplay her depression symptoms and focuses instead on her school performance.

Depending on their specific identities and circumstances, this period can be more complex for transitional age youth. Individuals may go through additional developmental processes based on their personal history, identity, and cultural background. Models have been generated to demonstrate the phases of identity formation and acceptance for several such populations including racial or ethnic minorities, individuals with migration histories, gay/lesbian/bisexual individuals, and White/dominant cultural members [25]. For example, Fig. 21.3 highlights the developmental stages of LGB sexuality as described by Garnets and D'Augelli [26]. These developmental tasks are not necessarily completed at specific


**Fig. 21.3** Developmental stages in LGB identity formation [26]

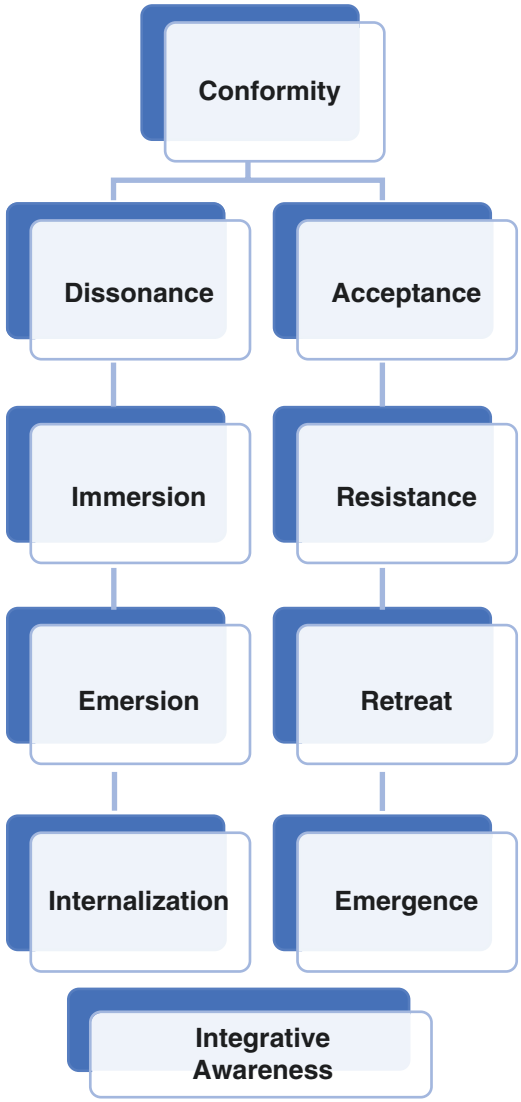


**Fig. 21.4** Integrative Model of Racial Identity Development. (Adapted from [34])

stages of life, but occur over time with the influence of personal, community, and societal factors. Hoffman's Integrative Model of Racial Identity Development is shown in Fig. 21.4.

The Integrative Model combines models of identity development in undervalued (people of color in the United States) and dominant (White people in the United States) cultural groups. It represents an integration of many models proposed for specific groups by others including Black Racial Identity Models by both Cross [27] and Helms [28, 29], the White Racial Identity Model by Helms [29, 30], and the Filipino American Identity Development by Nadal [31, 32]. Acculturation [33] and multiracial [32] models are also included.

In the Integrative Model, everyone begins in "conformity" where conscious awareness of one's own race is minimal, and the dominant culture is held as a positive standard. At the next stage, people of color and White people diverge to "dissonance" and "acceptance," respectively, and they remain divergent for the next four stages. In "dissonance," confusion between having upheld dominant cultural norms and a new recognition of the disparities of opportunity emerges. Also, the discovery of racism or acceptance of other biases as reality is at the heart of the dissonance stage. This stage is typically precipitated by a significant event, such as a personal or national trauma. In contrast, acceptance for White people involves some recognition of disparities as "universal struggles" such as "we can't all get the job" or "they must not have been a good enough student to get into that school." These "struggles" are dismissible under the guise of universality or being "the way the world works" and potentially applicable to any person regardless of race (or other minority status). For people of color, "dissonance" is followed by "immersion" – where the disillusionment of "dissonance" leads to anger and frustration that the dominant culture has created and perpetuates the problem. This flows into the next stage, "emersion," where individuals of the underrepresented cultural group affiliate with their own group to avoid the other problematic group. In this model, the parallel two steps for the dominant group are "resistance" and "retreat." Resistance occurs where disparities such as racism are acknowledged as a thing of the past and "reverse racism" against the dominant culture may be touted as the current climate. Reverse racism occurs when a White or majority group person assumes that their own opportunities are limited by systemic or societal responses to racism, for example, the claim that being an ethnic minority makes it "easier" to be accepted to jobs or academic programs and therefore makes it harder for White or major-

ity people to get those coveted positions. "Retreat" begins with realization of the falsehoods of reverse racism beliefs and then moves into feelings of guilt or shame about ongoing disparities for the underrepresented culture. In "retreat," White people can be frustrated toward their own culture for not yet understanding its role in maintaining disparities. The underrepresented group moves out of "emersion" and goes on to "internalization" where their own group's negative qualities come into recognition. The "problem" shifts away from the whole dominant group to the inequalities themselves. In this stage, psychic space opens up to allow more expression of individual identity, for example, recognizing an intersectional identity that is more than race alone.

Coined in 1989, the term "intersectionality" was first used to describe women of color and how their identities both as women and people of color together handicapped them from prominence in both the feminist and civil rights movements [35] and has subsequently grown to encompass the interplay of different identities within one individual. "Intersectionality is a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression (i.e., racism, sexism, heterosexism, classism) at the macro social-structural level" [36] (p. 1267).

The individual within dominant culture makes similar intersectional identity gains in the stage of "emergence" following retreat. They grow to understand the impact of dominant culture privilege in their life and recognize that there is choice in what type of person they want to be within this frame. Hoffman's Integrative Model ends with "integrative awareness" for both groups, where the individual is able to positively identify with their own racial group along with other aspects of their unique identity [34].

TAY may be operating at any stage within this model. Understanding their place within it could be very helpful in conceptualizing their presentation and planning their care [29]. From the case examples, several of the individuals and their families are at different stages of racial identity development. Maaria is "taking a break from religion" and may be in the beginning stage of conformity, where she identifies more with the dominant or majority culture than her family's stated religion. Could William's panic attacks be related to the dissonance stage of racial identity development, where he is realizing that his mother was pulled over for something a White driver might not have been? For Jerome, there is not enough information from the case vignette alone to determine with confidence which stage he is in. His interest in protesting could be fueled by anger at the disparities he sees, and it sounds likely as his parents report he has been irritable and unhappy. This is consistent with the immersion stage. However, with more information from him, we might learn that he has recognized racial disparities but also sees positive and negative features of both his own racial group and the majority group which is more consistent with the stage of internalization. It is also important to understand his parents' stage in this developmental process in order to identify and address tensions in the family related to discrepant stages of racial identity development.

## Delayed Adulthood

Family and community cultural values affect youth's journey of identity formation, and TAY's individual identities can both help and hinder them in facing the social and cultural challenges of this developmental period. Some of society's goals and pressures on transitional age youth may differ from past generations. Unfortunately, there are disparities in future trajectories for minority or immigrant TAY experiencing acculturative stress and discrimination. Black and Latinx young adults are less likely than Asian and non-Latinx White peers to be enrolled in post-secondary education, and Black and Latino men are more likely to be incarcerated. The same groups are more likely to start "family building behaviors" such as cohabiting, parenting, and

marrying before age 25 years than their peers in other ethnic groups [18]. Although it is an intergenerational gain to obtain higher education degrees, TAY postponing gainful employment have more financial debt [37]. According to Rumbaut [38], up to 60.7% of the second generation of 18- to 24-year-olds remain at home with their parents but have the overall highest educational attainment with up to 34.6% having received a bachelor's degree or higher.

Surveyed ethnic minorities expressed a desire of opportunity for upward social mobility which was influenced by their parents' often low-status work [19]. However, each individual's unique trajectory should be considered rather than making assumptions based on a demographic.

Many TAY are relying more heavily on their parents while they transition from adolescence to adulthood, by living at home, asking for financial support, or by staying on their family's health insurance plan. Although the passage of the Patient Protection and Affordable Care Act has helped increase healthcare coverage, young adults in the foster care system and unauthorized immigrants are two groups which continue to struggle to obtain reasonably priced high-quality healthcare [37]. TAY are historically the least insured of any age group, which is complicated by "aging out" of pediatric health service systems and therefore threatening continuity of care [37]. Continuing to reside in the family home during early adulthood can help with finances and can foster an ongoing connection to family at this potentially difficult time [19].

Both external support and a positive sense of personal identity increase success in navigating this period of intense growth toward achieving independence. Demographic transitions are difficult to predict and have a low impact on achieving "adulthood." Rather, accepting responsibility for one's self and making independent decisions are the most necessary steps for transitioning to adulthood [22]. Moreover, it is important to remember that different sociocultural variables set the expectations of what is expected for these youth: both in the society in which they currently live and in the heritage with which they may choose to identify [22]. Overall, youth will continue to navigate their identities as they are transitioning to adulthood. Concepts of race, gender, privilege, and other societal constructs become increasingly salient during this phase of life. Specific aspects of identity may change over this period as they contemplate what is more and less important to them.

## Modern Society and Future Considerations

### Current Political/Social/Cultural Perspective

The diversity of the population of the United States is estimated to continue to grow, with different ethnic and racial minority groups, multiracial groups, internationally adopted children, and immigrants [39]. There continue to be thousands of people (nearly 85,000 in 2016) with refugee status who resettle in the United States, the majority of them from Somalia, the Democratic Republic of the Congo, Burma, Syria, and Iraq [40]. This will lead to an increase in multiple languages spoken within the country and more diverse children living in settings such as foster care, migrant families, and homelessness [39].

With such a diverse population, one must consider acculturation, which is defined as "the process of social and psychological exchanges that take place when there are ongoing encounters between individuals of different cultures, with subsequent changes in either or both groups" [41] (p. 149). Indeed, Berry [42] described it as a "bidirectional and bidimensional process" which affects a person's identity within an "open/inclusive or closed/exclusive" society as well as the smaller groups within that society [43] (p. 38). When determining factors which impact a cultural identity, there have been four strategies proposed which include integration, assimilation, separation, and marginalization. Those who maintain the culture of origin while also becom-

ing part of the new culture are believed to have employed the integration strategy. While assimilation suggests a loss of the original culture, separation prioritizes close ties to the culture of origin, and neither the new nor the former culture provides support for marginalized individuals [44].

Refugees, in addition, face logistical barriers when accessing both preventative and specialty care such as language, finances, resource availability, and stigma [40]. For this population, psychological distress can be a result of trauma involving their pre-migration experiences [3]. There is also a fear among some nonimmigrants that immigrants, refugees, and others who hold onto non-US culture and values will water down what they consider to be American-held values and/or beliefs [44]. According to Perez and Fortuna [45], undocumented immigrants endure more socioeconomic stressors as well as fear of deportation which result in greater risk for mental illness including substance use disorders and depression. In the case examples, this fear inevitably affects Lily and her family. Immigrants could be at higher risk of traumatic disorders but also less likely to seek help based on previous experiences with healthcare and uncertain immigration status [46]. Lily's family may be less likely to seek care than documented immigrants or citizens, and may be more guarded with providers, given their real concerns about deportation.

Providers should also, then, consider the potential acculturative stress on individuals, especially for TAY whose families hold tightly to a home culture, as well as how they value different elements of their identity. Specific issues these populations can face include "financial stressors and poverty, language barriers and communication difficulties, lack of access to healthcare, unsafe neighborhoods, poor housing, unemployment, underemployment, exploitation, and dangerous working conditions" [44] (p. 96). This is compounded by TAY's "heightened risk for excess emotionality, reward seeking, and poor judgment" [47] (p. 887). For example, Lily in case 3 must consider how well she fits into American culture, not only for her own identity but also for her sense of belonging, which is complicated by the added stresses of her and her family's legal status. This is a possible explanation for her nickname of "Lily," as opposed to her longer name "Lilliana." Meanwhile, Abraham in case 9 is more free to choose which parts of his Latinx, US, or Western experiences speak to him more. Alice, from case 6, has to consider her ties to her family's culture, in comparison to their desire to fit in with US culture, which is evident in her very name. Even Maaria in case 1 has to consider her name, and whether to emphasize its South Asian pronunciation or a more Western-acceptable form.

## Explicit and Implicit Biases

In thinking about diversity, especially when there are externally visible distinguishing factors such as skin color, clothing or other religious identification, language proficiency and accent, and body shape and size, we must consider bias. In regard to explicit bias, there have been studies in which physicians provided lower ratings on factors including intelligence and likelihood to adhere to medical advice for African American patients and those from lower socioeconomic backgrounds compared with Caucasian Americans and patients from higher socioeconomic backgrounds [9]. There has also been negative bias against African Americans and working-class patients documented among mental healthcare professionals. When an experiment left voicemails for therapists seeking appointments, fewer working-class individuals were given appointments compared to middle-class individuals, and among the middle class, Blacks were less likely than Whites to be offered appointments [9]. Many of the patients described in the case examples have backgrounds with historical or current bias against their identified groups to highlight these considerations. In addition, attention must also be given to microaggressions, "broadly defined as behaviors that ambiguously disempower racial minorities,"

including microassaults, microinsults, and microinvalidations [48]. People subject to microaggressions are more likely to report mental health concerns, and microaggressions themselves can create barriers to healthcare including implicit discrimination or insensitive interactions [48].

Taking measures of implicit bias into consideration can be illuminating when addressing topics which are politically, culturally, or socially sensitive. This can include discussions on race, gender, religion, and obesity. Implicit bias involves associations and attitudes that may influence judgment and behavior which are outside an individual's conscious awareness and/or intention [49]. With regard to biases about social groups, in-group bias designates favoritism toward ones' own social group, whereas outgroup bias is a negative bias toward individuals from another social group [50]. Using free, online tools such as the Implicit Association Test (IAT) can increase awareness of any biases which may exist by testing automatic associations between concepts [51].

In examining implicit associations among healthcare providers, Cooper, et al. studied associations between physician implicit bias toward Black and White people, in general, as well as physician implicit bias toward "generic" Black and White patients regarding their likely compliance with medical advice. Both measures demonstrated moderate pro-White bias [9]. Maina et al. [52] also discuss that although healthcare professionals of various training levels have implicit biases against "Black, Hispanic, American-Indian and dark-skinned individuals," Black people who are healthcare professionals are the least likely to have implicit bias when compared to other groups. There remains a lack of intervention studies with only one showing reduced implicit bias among healthcare professionals in post-intervention measures [52]. Furthermore, there is evidence that clinician bias can result in misdiagnosis of psychiatric illness in minority populations [53] and that certain minority groups (such as African American and Latinx) overall are less likely to receive accurate diagnoses [46].

## Effects of Bias on Healthcare-Seeking Behaviors

According to the Institute of Medicine, disparity is defined as the lack of access to adequate healthcare or providers, communication difficulties, cultural barriers, and provider stereotyping all of which are "racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention" [8] (p. 3). This negatively impacts healthcare-seeking behavior in the United States as minorities experience a distrust of the healthcare system due to perceived racism [7]. In addition, the IOM reported that racial and ethnic non-minorities receive better-quality healthcare than their minority counterparts, despite controlling for access-related factors including insurance status. Having limited English proficiency (LEP) resulted in even lesser quality care [8]. Also, there are disparities in mental health outcomes for racial and ethnic minority children and adolescents, namely, that they "are at elevated risk of persistent mental disorders in adulthood," possibly due to risk factors that hinder improvement [5]. Alegria et al. posit four mechanisms: socioeconomic status (proportionately more Black and Latino children and adolescents live in poverty than Whites), childhood adversities (of which there are higher rates in people with mental disorders and they are more common in minority populations), family structure across development (there has been an increase in single-headed households in racial and ethnic minorities), and neighborhood-level factors (ethnic minorities are more likely to live in high-poverty areas with more segregation). These differences in social class, risk factors, family support, and social support could contribute to disparities [5].

## TAY and Family Involvement

The parents of transitional age youth are still involved with and often advocate for their youth's medical and mental healthcare. Efforts should be made to not disempower parents or

unnecessarily marginalize TAY roles. This transition is also a developmental stage for parents. Exploring the parents' individual backgrounds including where they were born and raised and how this affects the child's cultural identity is important [54]. These conversations require the TAY's permission and must be done in a way that makes the patient feel safe. Consider this in the case example of Lily, in which it would behoove a provider to make sure she fully understood the confidential nature of her relationship with a mental healthcare provider and reassure her of her and her family's safety within the encounter. Also consider the case example of Alice, whose desire for independence may make her less inclined to include family in her treatment. Awareness of parent/child differences can also help unmask intergenerational conflict caused by differing new and traditional values which Hovey [55] has identified as a specific acculturative stressor for Latinx children. Parental worries about behaviors such as sexual activity or drug use, which can be issues for all TAY, should be explored [56]. Going back to the case examples, Lily may try to avoid these discussions, and the clinician can explore her fears and provide realistic reassurance. Abraham and Becca may find that understanding their parents' perspective is helpful as they discuss current relationship and sexual identity issues with their families.

Incorporating family support systems when considering how to resolve conflicts is important. Kobus and Reyes [57] found that Mexican American adolescents identified speaking to their mothers as a useful coping skill. Familism, which is a common Latinx value, is defined as a "strong identification and attachment of individuals with their families (nuclear and extended) as well as strong feelings of loyalty, reciprocity and solidarity" [58] (p. 398). Families often choose to reside close to other family members allowing for increased engagement [59]. Similarly, collectivism allows one to form self-identity through being part of a community [60]. A loss of social support can be a particularly acute stressor for many TAY immigrants who may prioritize collectivism over individualism [55, 61–63].

In the case examples, Maaria, Sam, Becca, and Adenike all come from religious households, but not all of them identify with their family's chosen larger religious community, which may be further navigated and explored. In addition, Sam and Adenike have different backgrounds and clinical presentations, but members of both of their families express preference for prayer over standard mental healthcare – consider how a provider should engage families in conversations about evaluation and treatment. Religious involvement has been found to be protective for adolescent mental health by providing social support as well as a sense of meaning and coherence [19]. Regardless of affiliation, religious communities can provide wider family support within a group that shares norms and values. Religious involvement may reinforce more "authoritative" parenting in addition to bolstering resilience by teaching coping skills [19].

## TAY with Disabilities

For youth who have disabilities, it is fundamentally important that they understand the impact of their disability on their identity. The International Classification of Functioning, Disability and Health (ICF) model states that disability is "a function of one's health, environment, and personal factors: a health condition may result in a disability through an impairment that affects one's body structure or function, an activity limitation that affects one's ability to execute a task or action, or a participation limitation that affects the individual's ability to be involved in a societal or life situation" [64] (p. 750). For Alice's and Jerome's case example situations, their medical illnesses have impacted their participation in some childhood and adolescent activities, and both struggle with wanting increased independence moving forward. In the case example of William, his anxiety and subsequent panic symptoms are affecting his ability to drive, thereby limiting his independence.

The impact of disability will likely evolve as youth transition to different work or settings where they experience a loss of services despite

no change in their health condition. Socially, children with disabilities reported "social exclusion is more troublesome than the physical restrictions associated with their disability" [65] (p. 56). While experiencing discrimination negatively impacts life satisfaction, a sense of belonging has been found to be associated with improvements in a youth's life satisfaction [65]. Referring again to the case examples, Alice in particular, due to restrictions post-bone marrow transplant, is experiencing a sense of isolation from her peers, as well as feeling "stuck." When she compares herself with them, they have been able to move onto independence furthering tasks, such as secondary education and employment, whereas she feels left behind.

## Cultural Formulation and Conceptualization

As the United States becomes more diverse – racially, religiously, linguistically – medical and mental health providers must consider cultural factors in diagnosis and treatment planning [53]. Specifically, they must consider how patients' cultural identities and backgrounds could affect symptom presentation and help seeking behavior [53], in addition to family understanding and involvement in treatment. Overall, providers should consider their own biases and seek to better understand that patients from different backgrounds may not present with classical symptom clusters.

The term culture "provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are the criteria for diagnosis. Culture is transmitted, revised, and recreated within the family and other social systems and institutions" [15] (p. 14). It adds meaning to those beliefs and values within a specific social construct and can be used to create models of normative expectations [66]. These models can be used in healthcare, to help define what falls within the parameters of "healthy" and what deviates from it, and providers can then interpret cultural and social significance of symptoms and illness [53].

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) Outline for Cultural Formulation (OCF) was first published in 1994, helping patients create symptom and identity narratives for evaluation and treatment [67, 68]. While it was vital to begin considering patients using cultural information, there have been many changes since 1994. Specifically, the field of cultural competency education has evolved from a categorical approach (i.e., teaching facts about particular racial/ethnic groups) to the development of a framework and a set of skills [69], including ethnographic interviewing [70].

Previous approaches were less able to convey the heterogeneity of cultural groups (e.g., lumping "Asian patients" together despite there being >40 countries in Asia with very different histories, politics, languages, and culture). In the case examples, Maaria and Alice both come from "Asian" backgrounds but have inherited very different cultures and beliefs. Similarly, "Spanish speaking patients" were combined, despite there being almost 20 distinct countries in which Spanish is spoken as a primary language [71]. In addition, there are also intragroup differences, where there are some similarities, and also many cultural differences (e.g., Jewish individuals from different locales) [71]. Heterogeneity includes not only geographic, religious, dietary, and language diversity but also socioeconomic, historic, and educational diversity. In the case examples of Jerome and William, who are both African American young men, there are many differences in terms of their privilege and upbringing, which affect their identities and presentation. Similarly, Lily and Abraham are both Latinx, but their experiences are very different given their difference in citizenship status.

One concern is that broadly grouping (i.e., stereotyping) can lead to mistaken assumptions about certain cultural factors while possibly ignoring other unrelated practical issues (such as transportation and finances) in the ability or desire to seek care [68]. In addition, there is the possibility of incorrectly presuming that people who undergo similar experiences will be similarly affected; however, experiences must be considered from the specific individual's per-

spective. For example, certain natural disasters are traumatic for a wide net of individuals, but their effects can be felt disproportionately by people from lower socioeconomic backgrounds, due to their limited access to resources and supports, and often more dangerous environments; they might suffer more consequent symptoms [46].

Another concern is overgeneralizing based on certain cultural parameters. In the case example of Adenike, there are certainly cultural factors that make it harder for her parents and particularly her mom to understand her illness. However there are also practical difficulties, including her parent's work schedule such that they cannot visit the hospital in the daytime, when there are more healthcare providers to give explanations and space for discussion. Ideally, the clinician should have a curious inquisitiveness about the patient's cultures, backgrounds, and experiences. However, providers must also consider the agency that individuals have in choosing which identities carry personal significance. Modernization of technology and globalization have allowed for more far-reaching cultural influences [71]. Instead of assuming or assigning an identity onto a patient, the clinician must explore how youth and their families self-identify, considering the different cultural influences involved and paying attention to differences between youth and their caregivers [72]. With this inquisitiveness, the clinician gathers information that allows them to better understand the nuanced way cultural influences either build resilience or lead to symptoms and discord. In the case example, Maaria tells the provider that she's taking "a break" from religion. Alice is trying to downplay the medical identity she has been forced to take on, trying instead to be a more typical teenager. Becca and Sam both identify as religious, though they also hold fears about being rejected by their communities.

Additionally, individuals can prioritize or minimize multiple aspects of their cultural identities, "such as nationality, religion, income, age, education, sexual orientation and gender," of which these "interact and influence one another" and affect a person's subjective experiences [46]. Different individual identities should be considered from a more holistic, intersectional perspective.

An intersectional lens would posit considering how multiple identity experiences, including some longstanding patterns of discrimination which have created inequalities, impact an individual and interplay with each other in social institutions [73]. Culture is not static and is in fact very much affected by the sociopolitical climate, the economy, and narratives from religion, psychology, biology, etc. [68]. For example, from the case examples, Maaria, Sam, and Becca must all contend with their conservative religious families and communities as they explore their sexual orientation and gender identities. William's middle-class background, and having family members who have been killed by gun violence, affects him as an African American man in a different way as compared to Jerome, whose upper-middle-class upbringing has been somewhat protective for him. As Black men, they may both have similar fears of driving, but their other life experiences shape how the fear affects them, and how they are able to cope (or not) with those emotions.

The OCF pieced together medical anthropology and cultural psychiatry to outline a format for providers to discuss cultural experience across four domains [74]: cultural identity; the patient's understanding of symptoms and their etiology; patient expectations of treatment; and stressors and supports [75]. These four domains were updated in the DSM-5 [15]. The OCF was created with the goal of recognizing a variety of cultural factors that could be affecting a patient and encourages the provider to not only consider, but explicitly inquire, about them. It also encourages providers to consider similarities and differences between children and adolescents and their caregivers and to consider transgenerational strengths and differences which could lead to tension [71].

However, there have been problems in the OCF's implementation, including that it provides insufficient guidelines or can be ambiguous or repetitive. Lack of clinician buy-in has also limited its use [76]. For DSM-5, the Cultural

Formulation Interview (CFI) was developed to help clinicians gather the information needed to complete the OCF. The CFI has 16 stem questions to elicit information for the OCF and an additional 12 supplementary modules as tools to help providers. As noted in the *DSM-5 Handbook on The Cultural Formulation Interview*, "The main goal of all the components of the Cultural Formulation Interview (i.e., the core CFI, the CFI-Informant version, and the supplementary modules) is to contextualize the problem that the patient presents in a complex multidimensional way -- within the context of the person's sociocultural world, sense of identity, and ways of experiencing and understanding psychological distress. This ecological examination of the patient helps the clinician to select the appropriate treatment approach in collaboration with the patient, to enhance the patient's engagement in care...improve the therapeutic bond, …promote positive expectancy, and to accomplish other key treatment goals" [77] (p. 45).

Using a model, such as the CFI, to gather information can help a provider be more organized and thorough in assessing different cultural factors that may be relevant to a patient's care. This is especially true if the provider and patient are from different backgrounds. Even with shared cultural backgrounds, however, there can be obvious or subtle differences in experience and beliefs which could be clarified by a systematic method as groups can be heterogeneous [53]. After obtaining information guided by the CFI, the provider can conceptualize the patient on a variety of cultural parameters in a more nuanced way [71] to better understand their patient's intersectional identities, which can then help with the overall psychosocial formulation. This information can then be used in conjunction with a variety of psychiatric conceptual models to better understand a young adult's symptom expression, with the hope of forming a more accurate diagnosis to guide treatment.

## Practical Guidelines and Tips

1. Utilize the tools that are available and familiarize yourself with the OCF and CFI.
2. Be aware of the normal range in appropriate development across age and cultural backgrounds, and ask patients about any issues that may impact developmental progress.
3. Encourage patients to share their expertise in their identity development, and empower them to develop their own goals and areas of concern. Ask about how youth self-identify and how supported they are in these identities. Acknowledge any struggles with these identities, and explore with the youth's family and/or friends how the different identities manifest. Incorporate general questions about the following issues into your regular histories, and explore specifics as the provider-patient relationship grows:
   (i) Gender and sexual identity
   (ii) Migration history and family migration history
   (iii) Relationship with own ethnic/cultural group
   (iv) Conflicts with familial/community identity vs. patient's individual identity
4. Encourage youth's understanding of independence including the balance between occupational goals and their post-secondary educational goals or career.
5. Strengthen youth's ability to navigate their medication regimen as well as restate physician recommendations in their own words.
6. Promote awareness of biases, and be attentive to any changes in behavior and/or communication with youth and families.

## Conclusion/Summary

The population of the United States is becoming more diverse, and racial and ethnic minority groups, and those from lower socioeconomic backgrounds, bear the brunt of healthcare disparities. In addition, there are sociocultural factors delaying the transition from childhood to adulthood during this crucial time of transition, when youth explore their personal identities. In order to be more effective in symptom collection and treatment planning, mental healthcare providers must better understand identity formation. They can use guidelines such as the OCF or CFI

to elicit information from patients to obtain a more complete understanding about why patients choose their specific cultural identifiers, whether those identities have affected their life experiences, and how they have interplayed with each other to help culturally conceptualize patients. Understanding these factors will allow them to provide more comprehensive care.

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