

Resource Document on Cultural Psychiatry as a Specific Field of Study Relevant to the Assessment and Care of All Patients

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 - *APA Operations Manual*.

Background and History of Cultural Psychiatry

The comparative study of mental health and mental illness among diverse societies, nations, and cultures and the multiple interrelationships of mental disorders with cultural environments have occupied the interest of individual psychiatrists and psychiatric organizations in the U.S. and abroad for many years. The growth of international collaboration in psychiatry since World War II, the many advances in clinical methods and research, particularly in the last several decades, have greatly enhanced interest in the field, as has the rapprochement of psychiatry with cultural anthropology, sociology, and behavioral sciences. The phenomena of globalization, the impact of migration, the progress in technology and its communication products, the ease of modern international travel, and a variety of other factors has quickened the pace of development.

H.B.M. Murphy of McGill University founded the World Psychiatric Association (WPA) Section on Transcultural Psychiatry in 1970 and the Society for the Study of Psychiatry and Culture in 1980. Wen-Shing Tseng from the University of Hawaii founded the World Association of Cultural Psychiatry (WACP) in 2005. An impressive body of literature has evolved including the foundation of four journals. In 1956, the *Transcultural Psychiatric Research Review* (now *Transcultural Psychiatry*), edited by Dr. Eric Wittkower, began publication as the first specialized journal demarcating the field and is the official journal of the WPA Section on Transcultural Psychiatry. Arthur Kleinman, one of the pioneers in cultural psychiatry established *Culture, Medicine and Psychiatry*, a cross-cultural peer-reviewed medical journal, in 1976. The *World Cultural Psychiatry Research Review* in 2006 emerged as the official journal of the WACP and the *International Journal of Culture and Mental Health* began publication in 2007. In addition, many journals of general psychiatry and other sub-specialties have printed articles dealing with clinical cultural psychiatry issues. For instance, *World Psychiatry*, the official journal of the WPA, has devoted space to articles on diagnostic, educational, and clinical aspects of cultural psychiatry.

The DSM-IV-TR contains an Outline for Cultural Formulation and a glossary of Culture Bound Syndromes as well as an Age, Gender, and Culture section in the narrative section for 79 of the diagnostic categories. DSM-V

will include a sixteen question Cultural Formulation Interview (CFI) with 12 supplementary modules including the Explanatory Model, Level of Functioning, Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, School-Age Children and Adolescents, Coping and Help-Seeking and the Patient–Clinician Relationship. Since 1975, the U.S. government has supported the APA Minority Fellowship Program, which strengthens a resident’s cultural psychiatry training by providing support through grants from NIMH, CMHS and SAMHSA for cultural competence training, research in cultural psychiatry, and the development of new services. The field of cultural psychiatry is aligned with the following three Goals of the APA (*Operations Manual*, 2012): 1) To improve access to and quality of psychiatric services, 2) To improve research into all aspects of mental illness, including causes, prevention, and treatment of psychiatric disorders, 3) To improve psychiatric education and training.

In 1964, the APA Board of Trustees established a Committee on Transcultural Psychiatry, which was replaced by the Council of Minority and National Affairs, and in 2002 renamed the Council of Minority Mental Health and Health Disparities (CMMHHD). The Council and OMNA (Office of Minority and National Affairs) have supported minority and under-represented groups interests through position statements, action papers, presentations at national meetings, awards, fellowships, and publications. In a 1969 position statement, the APA recognized transcultural, or cross-cultural, psychiatry (also known as cultural psychiatry) (1). The position statement succinctly delineated psychiatry’s role in transcultural studies, clarified the terminology of the field, described its interdisciplinary nature, and outlined its major objectives, problems, and areas of application. Since then, theoretical principles of cultural psychiatry have expanded due to definitive advances in clinical recognition of cultural components in the patient’s history and their impact on diagnostic and therapeutic approaches, plus solid accomplishment in research (including studies on bio-cultural connections). Further, Cross et al.’s (2) seminal work helped define cultural competence as a continuum between cultural destructiveness and advanced cultural assessments. Establishing this definition was a key step in operationalizing cultural competence conceptually and systemically the overall field of cultural psychiatry.

Important regulatory milestones in the development of the field include the Title VI Civil Rights Act of 1964 (3), which forbade discrimination on the basis of sex and race in hiring, promoting, and firing. The Americans with Disabilities Act (ADA) was passed in 1990 (4) and prohibits private employers, state and local governments, employment agencies, and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and

privileges of employment. In 1993, the State of California became the first state in the country to mandate that each of its 58 counties create a Cultural Competence Plan to assess the race/ethnicity, gender, and languages of their mental health patients and providers. The Plan required that they provide services and brochures in any language spoken by 3,000 non-English-speaking Medi-Cal members or 5% of the Medi-Cal population (5). In 1997, New York initiated similar requirements by publishing the New York State Cultural and Linguistic Competency Standards (6).

Professional organizations such as the American Counseling Association (7), the American Psychological Association (8), and the National Association of Social Workers (9) issued their own guidelines on how to implement cultural competence standards. The APA published in 1994 the DSM-IV, which included a groundbreaking Outline for Cultural Formulation, and in 2003 the *Practice Guideline on the Psychiatric Evaluation of Adults* (2nd edition), included it in the text (10). The APA Council on Aging produced a *Curriculum Resource Guide for Cultural Competence* in 1997 (11) that was revised in 2006. Following a pair of conferences sponsored by the Center for Mental Health Services (CMHS), the Accreditation Council of Graduate Medical Education (ACGME) Residency Review Committee (RRC) incorporated cultural competence requirements into its Guidelines for Psychiatry Residencies (12).

Other national agencies supported cultural competence, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the Office of Minority Health (OMH), and the Office of Civil Rights (OCR). In 1997, the Western Interstate Commission for Higher Education (WICHE) developed a SAMSHA-funded report entitled *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups* (13) that outlined core cultural standards for mental health treatment and objectives for training in serving Latinos, African Americans, Native American/Alaskan Natives, and Asian/Pacific Islander Americans. This work involved four national panels (representing each racial/ethnic group) that met together in Washington, D.C., to reach consensus standards for all four racial/ethnic groups.

These standards present demographic and health profiles for the four major racial/ethnic groups. They also identify 16 "Guiding Principles" (i.e., consumer-driven and community-based systems of care and natural support). Specific standards of quality care are identified along with associated implementation guidelines. Appropriate performance indicators and recommended outcomes also are delineated.

The OMH produced the *National Standards on Culturally and Linguistically Appropriate Services* (CLAS) (14), which described 14 standards for health care organizations when providing health care (including mental health care) to ethnic minorities. Finally, the OCR, empowered by an executive order from the White House, required that all federal agencies formally address how they would provide access to their services to clients with Limited English Proficiency (LEP) (15).

Four other documents were important to raising the mental health community's awareness of the disparities that ethnic minorities experience. In September 2001, the Surgeon General David Satcher, MD, published *Mental Health: Culture, Race, and Ethnicity*, the supplement to the Surgeon General's report on mental health, which for the

first time highlighted that "the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity." The supplement (16) established that ethnic minorities do not use services as much as the majority population even though "culture counts."

In response to the report, APA President Richard K. Harding, M.D., convened an APA Steering Committee to Reduce Disparities in Access to Psychiatric Care. After careful deliberation, the Committee developed a "Plan of Action" approved by the Board of Trustees in 2005 consistent with APA's mission and goals. This plan made four broad-based recommendations. *First*, expand the science base by gathering and disseminating new knowledge with specific recommendations like continued study and publishing findings on racial and ethnic disparities in mental health. *Second*, support education, training and career development by fostering "capacity development" to reduce mental health disparities while noting, "Minorities are underrepresented as providers, researchers, and as administrators and policymakers and consumer and family organizations. Furthermore, many providers and researchers of all backgrounds are not fully aware of the impact of culture on mental health, mental illness, and mental health services." *Third*, enhance access and reduce barriers to mental health services for racial and ethnic minorities. *Fourth*, promote advocacy and collaboration to reduce racial and ethnic mental health disparities by forging coalitions with other allied health organizations and with consumer and family advocacy organizations such as the National Alliance of the Mentally Ill (NAMI) and the National Mental Health Association (NMHA).

The President's New Freedom Commission Report on Mental Health (17) highlighted the need for serving ethnic minorities and rural populations with culturally-competent services, to improve access and decrease disparities. In March 2002, the Institute of Medicine issued *Unequal Treatment; Confronting Racial and Ethnic Disparities in Healthcare*, (18) which documented disparities in access and quality of care for racial and ethnic minorities for many medical conditions. The report pointed out that the minorities are disproportionately more likely to be uninsured and overrepresented in publicly-funded health systems. Moreover, even among racial and ethnic minorities with similar health insurance statuses as whites, these health care disparities persisted. The IOM report stated that physicians' stereotypes and biases about race and ethnicity affected their judgment of the severity of the patient's illness and their interpretation of their presentations during clinical encounters due to race and ethnicity could potentially contribute to healthcare disparities. The report cited research studies that demonstrated disparities in care based on racial and ethnic differences during a clinical encounter. In addition, the report cited the characteristics of health systems that contribute to healthcare disparities. The document offered suggestions to eliminate racial and ethnic disparities in healthcare by educating both the patients and providers using culturally-appropriate programs to improve their knowledge of accessing care and their ability to participate in clinical-decision-making, raising public and health care professionals' awareness of the problem, intervening at the health system level through targeted resource allocation, policy decisions in terms of payments to providers at a

level paid by private insurers, and regulations to monitor the care delivered.

In 2006, the Agency for Healthcare Research and Quality (AHRQ) (19) began to publish the annual *National Health Care Disparities Report*, which confirmed that disparities based on race, ethnicity, and socioeconomic status continued to exist and have a devastating personal and societal cost. The report emphasized the need for reduction of barriers to care, preventive care, and further research in health disparities. The 2009 *Disparities in Psychiatric Care: Clinical and Cross-Cultural Perspectives* edited by Drs. Pedro Ruiz and Annette Primm also expanded the understanding of mental healthcare disparities related to race/ethnicity, gender, socioeconomic status, geographic location, among many factors (20). Finally, the APA *Position Statement on Diversity* supports the development of cultural diversity among its membership, trainees, faculty, research and administration to prepare psychiatrists to better serve a diverse U.S. population (21). The focus is on the recruitment of a diverse workforce that can support the development of “knowledge of cultural factors in the delivery of mental health care and in patient health-related behavior in graduate and under-graduate education, in faculty development, and in clinical practice.”

Psychiatrists and Cultural Psychiatry

The 1969 *Position Statement on Transcultural Psychiatry* stated that psychiatrists have as a principal concern “the study of how human beings think, feel, and act with reference to the sociocultural contexts in which they are reared or live as adults.” The authors go on to state that

psychiatrists are active investigators in this area by virtue of their concern, as physicians, with matters of health and disease, and because their clinical training uniquely equips them to study human behavior. They are familiar with mental functioning, in its covert as well as overt aspects.... All of these factors especially fit psychiatrists to engage in studies of the relationship between culturally institutionalized practices, motivational factors, character traits, individual and group behavior, and potential mental health or disorders (1).

Help-seeking behaviors and diagnostic, therapeutic, and preventive activities should be added to this list.

Interdisciplinary Considerations and Labeling

Transcultural psychiatry is derived from social and biological sciences, clinical medicine and psychiatry, epidemiology, experimental and clinical psychology, and psychoanalysis (22). Thus, psychiatrists are most qualified to investigate the relationship “between individual behavior and sociocultural systems and subsystems.”(1) Transcultural psychiatry or cultural psychiatry, is also known as

cross-cultural psychiatry (23); crossnational, transnational, or international psychiatry; intercultural psychiatry; ethnopsychiatry (24); comparative psychiatry; and social psychiatry. This last label is often used to include the others. Some labels used more often by nonpsychiatrists are: psychiatric sociology, sociology of mental disease (25), comparative social research, comparative

behavior studies, [medical anthropology], and culture and personality studies. Much research so labeled may be regarded as within the proper domain of cultural anthropology, sociology, social psychology, or even history, but these do not always include adequate definition of the personal human variable in health and illness. Other work falls within the field of epidemiology, defined as the study of the form, incidence, and distribution of disorders in relation to demographic, social, and physical environmental factors. Still other research may be recognized as an aspect of human ecology. (1)

Also important is a proper understanding of the concept of cultural competence, as described by Cross (2), who provided a philosophical framework and practical ideas for improving service delivery to children who are severely emotionally disturbed in four socio-cultural groups: African Americans, Asian Americans, Hispanic Americans, and Native Americans. The cultural competence model is defined as a set of congruent behaviors, attitudes, and policies that enables an agency (or an individual professional) to work effectively in cross-cultural situations. Cultural competence may be viewed as a goal and a developmental process. Agencies, or individuals, can be in at least six stages along a continuum: Cultural Destructiveness; Cultural Incapacity; Cultural Blindness; Cultural Pre-Competence; Cultural Competence; and Cultural Proficiency.

Research in Cultural Psychiatry

Research has covered such themes as:

1. similarities and differences in the form, course, or manifestation of mental illness in different societies and cultures;
2. the occurrence, incidence, and distribution of mental illness or behavioral characteristics in relation to sociocultural factors;
3. sociocultural factors predisposing to mental health or to optimal function or to increasing vulnerability to or perpetuating or inhibiting recovery from mental illness or impaired function;
4. the forms of treatment or methods of dealing with people defined as deviant or physically or mentally ill that are practiced or preferred in various sociocultural settings;
5. the influence of sociocultural factors on the assessment of clinical psychiatric issues (such as therapeutic approaches, progress, and diagnosis) and the adaptation of established psychiatric principles to varying sociocultural contexts;
6. the relationship between culture and personality through studies of the character traits shared by members of the same society derived from exposure to similar patterns of child rearing and to positive and negative social sanctions;
7. the understanding of conflict in persons experiencing rapid social and cultural change;
8. attitudes and beliefs regarding behavioral deviance and the mentally ill, including the labeling of behavior;
9. the psychological and social adaptation of migrants, voluntary or involuntary, within or across national boundaries or those of the receiving society;

10. psychiatric or behavioral aspects of communication between individuals and groups from differing cultural or national regions;
11. response to varying culturally-based stressful situations; and
12. cultural determinants of transnational interaction and public policy decisions within nations.

Other projects may be aimed at the definition of particular behavioral states, relationships or processes unique to a socioculture. These may include studies of culture-bound reactions, syndromes, treatment methods, perceptual styles, and reactions to stress. Or they may be concerned with mass behavior such as group loyalties, the formation of stereotypes or misperceptions. All of these studies deal in one way or another with: 1) the relationships between the functions of whole sociocultural systems and those individual humans and groups who compose them (26), and 2) comparative aspects of sociocultural systems and their components. (1)

To this list, we would add the nature and magnitude of stigma, stereotypes, prejudices and discrimination. Stress syndromes were added to the DSM-IV in 2000.

Training in Cultural Psychiatry

Cross-cultural curricula have taken various forms, such as fellowships as seen at UCLA (27) and Harvard, where 39 fellows have trained since 1984, supported by grants from the National Institute of Mental Health (NIMH) to establish a program of research training in “clinically relevant medical anthropology” in the field of culture and mental health services at the Department of Global Health and Social Medicine (28). Others are imbedded within the General Psychiatry programs, such as UC Davis School of Medicine (29), Oregon Health Sciences Center (30), the University of Toronto (31), and the Cambridge Health System (32) while others are offered as special institutes, such as the program of transcultural psychiatry offered by McGill University in Montreal (33).

Academic Psychiatry has published cross-cultural curricula for psychiatry training programs originating from several Committees that reported to the Council of Minority and National Affairs/Minority Mental Health and Health Disparities on Gay Lesbian, and Bisexuals (34), Women (35), Native Americans (36), Hispanics (37), Asian Americans (38), and African Americans (39). The curricula for psychiatry training programs on religious and spiritual issues was published by the National Institute for Health-care Research in 1997 (40). The APA’s Council on Aging produced the APA Ethnic Minority Elderly Curriculum in 2006 (41). The Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee (RRC) requires graduate medical education programs in general psychiatry to provide training in sociocultural issues for 5 of the 6 core competencies, which are related to cultural psychiatry, in 2007. The WPA presented their template for undergraduate and graduate psychiatric education, which includes a section vi entitled “The Centrality of Cultural Competencies in the Teaching of Medical Students and Residents,” and describes knowledge, attitudes, and skills that should be learned by medical students and residents, including assessments and treatment planning (42).

Articles describing a comprehensive overview of strategies that stimulate a culture where diversity is an integral

part of the educational environment to descriptions of various psychiatric residency curriculums at the Oregon Health Sciences University, the University of Toronto, and McGill University in Montreal, which described an approach to supporting research through the use of training at McGill University. Further resources for developing cultural curriculum can be found in Tseng’s *Handbook of Cultural Psychiatry* (43), and in the American Psychiatric Publishing’s catalog, such as Lim’s *Clinical Manual of Cultural Psychiatry* (44), the Group for the Advancement of Psychiatry’s *Cultural Assessment in Clinical Psychiatry* (45), and Tseng and Streltzer’s *Culture and Psychotherapy* (46). Lu’s “Annotated Bibliography on Cultural Psychiatry and Related Topics” (47) is available online. The American Association of Directors of Psychiatry Residency Training (AADPRT) has chosen and published on its website two model curricula on cultural psychiatry: one from New York University and the other from the University of California, Davis (48, 49).

Culturally Appropriate Services

According to Cross (2), five essential elements contribute to an agency’s ability to become more culturally competent. The culturally competent system: 1) values diversity; 2) has the capacity for cultural selfassessment; 3) is conscious of the dynamics inherent when cultures interact; 4) has institutionalized cultural knowledge; and 5) has developed adaptations to diversity. Each of these five elements must function at every level of the agency. Attitudes, policies, and practices must be congruent within all levels of the agency.

Culturally-competent services incorporate the concept of equal and non-discriminatory services, but go beyond that to include the concept of responsive services matched to the client population. Four service models frequently appear: 1) mainstream agencies providing outreach services to minorities; 2) mainstream agencies supporting services by minorities within minority communities; 3) agencies providing bilingual/bicultural services; and 4) minority agencies providing services to minorities.

In designing services, the following should be considered: the concept of least restrictive alternatives; community-based approaches with strong outreach components; strong interagency collaboration, including natural helpers and community systems; early intervention and prevention; intake and client identification to reduce differential treatment of minority youth; assessment and treatment processes that define “normal” in the context of the client’s culture; developing adequate cross-cultural communication skills; the case management approach as a primary service modality; and the use of home-based services.

Planning for cultural competence involves assessment, support building, facilitating leadership, including the minority family and community, developing resources, training and technical assistance, setting goals, and outlining action steps. Not all agencies will approach the issue in the same way, and each will have a different timeline for development. Through this or similar planning approaches, organizations can avoid the perception that the task is unmanageable.

The National Standards for Culturally and Linguistically-Appropriate Services in Health Care (CLAS)-Final Report from the U.S. Department of Health and

Human Services Office of Minority Health (March 2001) (15) responds to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner and gives guidance on how to do so.

These standards for culturally and linguistically appropriate services (CLAS) were proposed to correct inequities in the provision of health services and to make these services more responsive to the individual needs of all patients. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7). CLAS guidelines are activities recommended for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13). CLAS recommendations are suggested for voluntary adoption by health care organizations (Standard 14).

The four standards organized around the theme Language Access Services are classified as mandates. They are consistent with the OCR's interpretation of Limited English Proficiency, and the APA supports their implementation. The standards state that health care organizations must offer and provide language assistance services without additional cost, in both verbal and written forms. Interpreters need to be linguistically competent—the use of family members and friends should be avoided, and signage should be provided in common languages encountered in the clinical setting.

Finally, there are examples of services that are provided in culturally competent settings, and consultation services that provide the cultural context necessary to develop a culturally appropriate treatment plan. The Transcultural Wellness Center is an example of Ethnic Specific Services, where the staff is chosen to represent and serve the cultures that are seen in the community (50). In the inpatient setting, San Francisco General Hospital has an Asian Focus Unit, which provides both interpretation and cultural brokerage (51, 52), and Bellevue Hospital in New York also has an Asian Unit (53). McGill has a cultural consultation service for three hospitals (54), which inspired Sacramento County to start a Cultural Consultation Service (55). Finally, Chen and others in New York City (56) reported on collaboration between the primary care clinic and the mental health clinic in the Charles B. Wang Community Health Center in which primary care doctors referred patients with mental illnesses to the mental health clinic in the same building and noticed an increase in utilization of the mental health clinic. The collaboration was known as the Bridge project and has proven to be replicable at other sites (57). These initiatives illustrate how services can be adapted or supplemented to provide culturally competent care.

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