

Culturally Competent Systems of Care for Children's Mental Health: Advances and Challenges

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ABSTRACT: There has been a remarkable growth in cultural diversity in the United States over the past 20 years. The population of minority groups has increased at a much faster rate than the European-background population in America, and faster even among children and youth. At the same time, minority youth face increasing disparities in their mental health and in access to mental health services. These are related to the multiple challenges they already face in socioeconomic status, but are aggravated by the lack of culturally competent services that can address their specific mental health needs within the context of their culture, family, and community. This paper reviews the current knowledge about the mental health of culturally diverse youth in the United States, and provides guidance on approaches to address the disparities they face.

INTRODUCTION

Recent demographic changes in the United States have underscored the centrality of cultural competence in mental health service delivery systems in child mental health. The past 20 years have witnessed a remarkable growth in the population of many minority groups, increasing at a much faster rate than the European-origin population. In many areas of the United States, including most large cities and

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many states, there are no longer numerical minorities, but a plurality of various ethnic, racial, and cultural groups. By the year 2050 there will be no numerical majority population in the United States, and for children and youth. These changes are most rapid in areas not typically associated with diverse populations, such as the South and Midwest (U.S. Census, 2000).

These growing minority populations comprise a wide array of races, ethnicities, and countries of origin. Most differ substantially in their value systems and beliefs compared to European-backgrounds populations. Many minority children, (particularly the four underserved and underrepresented ethnic/racial groups: African-Americans, Latinos/Hispanics, Asian-Americans, and American Indians) suffer from inequities in socioeconomic status, education, and access to culturally and linguistically appropriate health and human services. These are reflected in significantly lower mean household income and levels of education, higher mortality rates (including infant mortality), higher school drop-out rates, high teen pregnancy rates, unemployment, and higher rates of physical and mental health disparities. (U.S. Office of the Surgeon General, 2001).

IMPACT OF CULTURE ON DEVELOPMENT, HEALTH AND MENTAL HEALTH

A conceptual framework of the role of culture in health and human behavior is necessary to understand the health needs of culturally diverse children and populations.

Cultural Influences on Development

Human psychological development is a key process through which culture influences behavior and adaptation. Cultural values help define childrearing practices and developmental norms (including behaviorally and emotionally) and expectations for such landmarks as toilet training, when to leave a child unsupervised, readiness for expression of sexuality and intimacy, and readiness to leave the parental home. Expected role functioning in different contexts is culturally governed, including gender, familial, and occupational roles. Patterns of interpersonal communication are largely determined by culture. For example, amongst different Latino groups there are differences in affective expressiveness, with some being more reserved while others

are more expressive. Thresholds for problem behaviors and adaptive psychological strategies differ widely amongst cultures. For example, hyperactivity in male children is not seen as abnormal by different groups (including Latinos and African–Americans), while for others it may deviant (such as Caucasians and Asian–Americans). Some cultures value coping mechanisms such as sublimation of emotions, while others value humor, abreaction, and the use of rituals or artistic forms (Powell, Yamamoto, Romero, & Morales, 1983).

A child responds to such cultural expectations in their family and community. However, for most diverse children, this involves being conversant with at least two cultural systems. The optimal adaptation for minority youth is bi-culturality or even multi-culturality (de Anda, 1984). This implies the development of knowledge, skills, and understanding in at least two cultures; while the youth retains his/her original cultural identity, they become adept at interfacing with the mainstream culture. It also implies flexibility to operate in different cultural contexts, the development of a stable self image, selective adoption of the most adaptive values and beliefs of different cultures, and openness to different cultural perspectives. Inability to develop these characteristics can lead to marginalization into the culture of origin, over-acculturation to the mainstream culture, identity diffusion, or negative identity formation (Erikson, 1968). Sue (1981) suggests that the identity formation process in diverse youth can be assessed and interventions designed to facilitate the development of a healthy bi-cultural adjustment. However, behaviors offensive to the larger society are often exhibited during identity development, causing potential helpers (such as teachers, counselors, and even clinicians) to view a healthy but painful process as pathologic. Inappropriate or overly punitive responses can also inhibit healthy outcomes and contribute to identity diffusion.

Cultural Influences on Mental Health

Value orientation influences health beliefs and practices. For example, nature, time, and activity orientations influence health maintenance or preventive practices, perceived locus of control, and health risk behaviors. The roles of the family as arbiter of health practices and primary caregivers are influenced by relational value orientations. The roles of healers are culturally determined; some cultures expect healers to assume an authoritarian role, and others a more egalitarian role (Callan & Littlewood, 1998). Attributional beliefs about physical and mental illness are largely culturally determined, with illness viewed

through Western biopsychosocial beliefs, or through religious, spiritual, interpersonal, and/or supernatural beliefs. Culture defines the sick role, with “sick” individuals expected to behave in a fragile manner, continue functioning in spite of their illness, or have a special spiritual role for the society. Finally, cultural values and beliefs influence patterns of help-seeking behavior, with people of different cultures seeking assistance from neighborhood wise ladies or “co-madres”, traditional healers, physicians, or mental health professionals. The orientation of traditional healers and their healing approaches are governed by attributional beliefs, and their practices differ greatly from those of the professional establishment (ceremonies/rituals, incantations, prayers, herbal remedies, sweat lodges, spiritual counseling, etc.; Rogler & Cortes, 1993).

Culture has a major influence on how we experience, understand, express, and address emotional, behavioral, and mental distress. Somatization and anger, for example, are symptoms frequently associated with depression and anxiety disorders in minority youth (Malgady, Rogler, & Dharma, 1996). Different contexts for idiomatic expressions determine how distress is expressed (e.g. “feeling blue” has clinical meaning for Caucasians, socio/historical meaning for African–Americans, but is meaningless to Latinos and Asians). Cultural values also dictate who are reliable reporters and observers and with whom to discuss symptoms and problems (Bracero, 1998).

DISPARITIES IN MENTAL HEALTH SERVICES FOR MINORITY CHILDREN AND YOUTH

Minority children and youth face a number of barriers to effective mental health care. These include population barriers (socioeconomic disparities, stigma, poor health education, lack of activism), provider factors (deficits in cross-cultural knowledge, skills, patient-orientation, and attitudinal sensitivity), and systemic factors (services location and organization, training, culturally competent services, etc.). These barriers result in different types of mental health disparities amongst minority children and youth.

Misdiagnosis and Misalliance

There is significant evidence that psychiatric disorders are frequently misdiagnosed amongst culturally diverse youth. For example, Kilgus,

Pumariega, and Cuffe (1995) found African-American youth were assigned significantly more diagnoses of solitary conduct disorder and psychosis, fewer diagnoses of mood and anxiety disorders, substance abuse disorders, and personality disorders, and more frequent involuntary commitments than Caucasian youth on an adolescent inpatient service. However, both groups had the same level of aggressive and self-injurious behaviors during treatment. Hong, Pumariega, and Licata (2002) found diagnoses for Caucasian, African-Americans, and youth of other ethnicities in a state public mental health system were dependent on their relative minority/ majority status in their region.

Misdiagnosis largely originates from difficulties that clinicians from majority and minority origins have in addressing cultural difference. Effectiveness in addressing cultural factors is not only related to knowledge about the family's culture, but also the clinician's ability to form a patient- and family-centered alliance in which the clinician respects the family's knowledge and unique perspectives on the child, avoids stereotyping, and empowers them to make critical treatment decisions. Cooper et al. (2003) demonstrated that the failure to form such alliances contributes to significant barriers in assessment and subsequent use of health services by minority patients, while race-concordant clinician-patient pairs tended to prevent such misalliance.

Psychopathology Amongst Minority Youth

Risk factors for psychopathology are influenced by cultural background and immigration status. Risks for certain forms of psychopathology are common in mainstream populations, such as substance abuse, eating disorders, and suicidality, increase with exposure to Western cultural values and practices (Pumariega, Swanson, Holzer, Linskey, & Quintero-Salinas, 1992; Swanson, Linskey, Quintero-Salinas, Pumariega, & Holzer, 1992; De La Rosa, Vega, & Radisch, 2000; Miller & Pumariega, 2001). This increase in risk may result from loss of protective cultural values and beliefs (such as attitudes and taboos on the use of substances, suicide, and body image) and exposure to risk enhancing factors (such as immigration and acculturation stressors, media exposure, peer pressure, and less family support). Inter-generational conflict between more culturally traditional parents and more acculturated youth has been found to lead to increased substance abuse and conduct disturbance (Szapocznik, Scopetta, & Tillman, 1978).

While some studies have shown lower rates of depression amongst African-American youth than Caucasians (Angold et al., 2002), other

studies have found higher rates of depression amongst minority (including African-American, Latino, and American Indian) youth than Caucasians (Roberts, Roberts, & Chen, 1997; Doi, Roberts, Takeuchi, & Suzuki, 2001). There is also significant race/ethnicity by gender interactions, with depression being higher in African-American versus Caucasian males but comparable between African-American and Caucasian female children (Kistner, David, & White, 2003). Though suicide rates for minority youth had been traditionally lower, they have had recent epidemic and now equal or surpass those for white youth. American Indian youth now have the highest suicide rate of all ethnic groups in the United States, and major increases have been documented for African-American and Latino males as well as Latino females. Contributing factors in addition to mental illness include acculturation pressures, discrimination, gender role pressures, past traumas and losses, and poverty (Borowski, Resnick, Ireland, & Blum, 1999; Olvera, 2001; Willis, Coombs, Cockerham, & Frison, 2002).

Studies have pointed to higher rates of anxiety symptoms and diagnoses amongst minority children and youth (Glover, Pumariega, Holzer, & Nguyen, 1999). Minority youth are at higher risk for child abuse and its sequelae when compared to whites, especially given socioeconomic disparities (Randall & Parilla, 2001). Coupled with exposure to community and domestic violence as well as traumas incurred in the process of immigration, minority children and youth are more vulnerable to post-traumatic and acute stress disorder symptomatology (Cooley-Quille, Boyd, Frantz, & Walsh, 2001; Rothe et al., 2002). These symptoms are complicated by the loss of family supports and familiarity of surroundings resulting from immigration, acculturation, and marginalization (Guarnaccia & Lopez, 1998).

Though recent studies suggest lower overall levels of drug abuse by minority youth compared to Caucasians, there is still significant morbidity from alcohol, cocaine, amphetamines, and hallucinogens. Although minority youth may use fewer substances than white youth, they are more likely to develop substance use problems as adults if they use alcohol during adolescence (Pumariega, Kilgus, & Rodriguez, 2005).

Aggressive behavior has been frequently associated with minority youth. However, while there is no evidence of higher rates of behavior disorders independent of substance abuse, many other factors contribute to violent behavior by minority youth including acculturation pressures, domestic violence, poverty, and substance abuse (Grunbaum, Basen-Engquist, & Pandey, 1998). Though often over-diagnosed,

there is no evidence that psychosis related to schizophrenia or bi-polar disorders are more prevalent amongst minority populations than amongst whites (Kilgus et al., 1995). However, manic psychosis is misdiagnosed as conduct disturbance in minority youth (Disalver, 2001). Additionally, cultural context affects the phenomenology and expression of hallucinations and delusions in these disorders (Suhail & Cochrane, 2002).

The definition for culture-bound syndromes is outlined in the Cultural Formulation of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-TR, American Psychiatric Association, 2000). Many culture bound syndromes have combined acute anxiety, dissociative, and even psychotic symptoms. These have associated spiritual, supernatural, and interpersonal attributions consistent with the individual's culture. The prevalence of culture-bound syndromes in children and youth is unknown and requires further research, though it is likely that their prevalence is lower than in adults given their higher level of acculturation (Canino, Canino, & Arroyo, 1998).

Access to Mental Health Services

Minority youth in the United States face considerable disparities in their use of mental health care services. In addition to the previously listed barriers posed by our health system, many minority families are suspicious of the mental health system and are less likely to seek care in such a system. African-American families have past experiences with discrimination, oppression, and involuntary treatment in the mental health system (Sussman, Robins, & Earls, 1987). Hispanic families underutilize mental health services due to language and cultural barriers (Ruiz & Langrod, 1997), while Asians-Americans experience shame around mental illness (Gaw, 1993).

All of these factors result in significant underutilization of community mental health services by minority youth and their families. Zito, Safer, Dosreis, and Riddle (1998) studied children 5 through 15 years old, enrolled in the Maryland Medicaid system. They found that Caucasian youth were two and a half times more likely than African-Americans to receive any type of psychotropic medication, and African-Americans received fewer prescriptions and had fewer physician visits. These findings coincide with those of Cuffe, Waller, Cuccaro, Pumariega, and Garrison (1995) that African-American youth receive significantly lower rates of treatment than whites and stay in treatment half the time as white children. Latino children receive an

average of half as many counseling sessions (Pumariega, Glover, Holzer, and Nguyen, 1998), and receive significantly fewer specialty mental health services and at a later age (Hough et al., 2002), than Caucasians and African-Americans. Minority youth are less likely to receive multimodality treatment for ADHD (Bussing, Zima, & Belin, 1998). Additionally, there are fewer pediatricians, family physicians and psychiatrists practicing in inner city and low-income areas where minority populations live (Rowland, 1994).

Lack of access to services and ineffective services for minority youth has resulted in increasing numbers of them entering the juvenile justice and child welfare systems (Pumariega, Johnson, Sheridan, & Cuffe, 1995; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). In fact, youth entering into juvenile justice have a significantly lower rate of access to acute and outpatient mental health services compared to youth already served by mental health, but higher rates of residential placements (Pumariega et al., 1999).

CULTURAL COMPETENCE IN CHILDREN'S MENTAL HEALTH SERVICES

Cultural competence became one of the core principles of the children's system of care movement. Cross, Bazron, Dennis, and Isaacs (1989) defined cultural competence as a "set of congruent behaviors, attitudes, and policies found in a system, agency, or a group of professionals that enables them to work effectively in a context of cultural difference." They identified a spectrum of cultural competence which has been demonstrated by societies and their institutions over centuries, ranging from cultural destructiveness (genocide, lynching, ethnic cleansing), cultural incapacity (segregation, discrimination, immigration quotas, services which break up families), cultural blindness ("equal" treatment for all, but not making distinctions in services offered on differences in values or beliefs), cultural pre-competency (realization of differences but insufficient provision of services), to cultural competence. Few societies have achieved the last stage, cultural proficiency (provision of innovative culturally specific services and research.)

Clinical Application of Cultural Competence Principles

Cross et al. (1989) defined the qualities of culturally competent practitioners and agencies. For the individual practitioner, they included

qualities such as being aware and accepting of cultural differences, awareness of their own culture and the biases it may create, understanding the dynamics of working across cultures, acquisition of cultural knowledge, and acquiring and adapting practice skills to fit the cultural context of the client.

Cultural factors involved in the development or expression of symptoms or disorders need to be addressed in clinical evaluations. Differences in interpretation of emotional experiences, labeling and interpretation of symptoms, and degree of self-disclosure affect the cross-cultural and cross-ethnic validity of clinical assessment and most diagnostic instruments (Abreu, 1999). Results from any diagnostic instruments require interpretation within the youngster's socio-cultural context and support by careful clinical observation (Knight, Virdin, Ocampo, & Roosa, 1994). Factors such as stigma, social acceptability, and parental disapproval should be considered in evaluating critical symptoms.

Language and communication are critical in obtaining accurate clinical information and establishing a therapeutic alliance, especially with family members. However, translation and interpretation are typically considered a menial or informal task rather than one central to the clinical process. This is reflected in the use of telephonic translation services, untrained translators, and family members; particularly the use of siblings or the child without regard to the impact on family relations. This latter practice should be prohibited except in dire emergencies due to the adverse impact it has on children and on family relations. Interpreters should have proper training in both the skill of translation and in the content area of interpretation. They should understand the family's culture and address verbal, non-verbal, and implicit communications (Four Racial/ Ethnic Panels, 1999).

The cultural and family context of symptomatology (for example, normative crises such as grief or mourning) must be considered in the assessment of a minority child. One must also assess whether cross-cultural dynamics may play a role in the symptomatology (such as inter-generational conflicts around acculturation, discrimination, or marginalization from the majority culture or the youth's own culture). Additionally, whether a cultural healer or herbal remedy was attempted or considered (or failed) should be ascertained. The utilization of a cultural consultant, with the family's consent, can also be useful in dealing with issues related to traditional beliefs and values, as well as their potential distortion (for example, whether spiritual preoccupations are consistent with the family's cultural or religious practices or are a psychotic distortion).

Treatment of minority children must be contextual, addressing psychosocial and cultural needs. The clinician must evaluate and mobilize familial, neighborhood, and community resources, address environmental factors that contribute to behavioral problems, and enhance strengths the child and family bring to address the problem. The clinician should support parents in developing practical behavioral management skills consonant with their cultural values and beliefs. They must respect culturally established means of communication and family role functioning, but at the same time foster family flexibility in dealing with their bi-cultural offspring (Koss-Chioino & Vargas, 1999).

Psychosocial interventions should be consonant with the values and beliefs of culturally diverse youth and their families. Culturally diverse children and families are more accepting and responsive to psychotherapeutic approaches with a practical problem-based and interpersonal focus. Cognitive-behavioral and interpersonal therapies, which are oriented towards these principles, are being increasingly used with diverse youth, with studies suggesting good response (Williams, Chambless, & Steketee, 1998; Mufson, Weissman, Moreau, & Garfinkel, 1999; Rosello & Bernal, 1999). Psychoanalytically oriented interventions have tended to include inherent cultural biases, (such as encouraging separation-individuation and challenge of traditional parental authority and roles) which are counterproductive in working with culturally traditional families (Cabaniss, Oquendo, & Singer, 1994). However, when cultural values and beliefs are addressed, diverse youth can benefit from psychoanalytic therapy (Aslami, 1997).

Some therapists have developed specific interventions for particular ethnic and racial groups (Constantino, Malgady, & Rogler, 1994; De Rios, 1997). Group and family psychotherapy, particularly approaches that integrate cultural and ethnic identity themes, psychoeducation, and culturally consonant approaches, have also been reported as accepted and effective (Szapocznik & Kurtines, 1989; Salvendy, 1999). Mainstream interventions also need to be tailored when used to treat minority children. For example, minority children with ADHD and their families cooperated with and responded significantly better to combined pharmacological and behavioral treatment, while Caucasian children responded to pharmacotherapy alone, even controlling for socioeconomic factors (Arnold et al., 2003).

The integration of consultation and intervention by traditional healers and ceremonies from diverse cultures is an important component of culturally competent care. Such practices should only be pursued if they are acceptable and desired by the child and family

(Four Racial Ethnic Panels, 1999). Clinicians from the culture of origin are preferable, though clinicians knowledgeable about the family's culture and sensitive to its meaning and importance can also be effective. Referral to culturally competent clinicians or culturally specific programs has been associated with improved follow-up and treatment retention (O'Sullivan & Lasso, 1992). A value-neutral approach, where the clinician models openness to the diverse cultural influences on the child, is effective in achieving these goals (Ponterotto, Casas, Suzuki, & Alexander, 2001). The therapist can also use judicious self-disclosure with the child when he/she experienced any of these conflicts. Confidentiality in psychotherapy must be addressed so the clinician is not perceived as "driving a wedge" between the patient and family, nor used by the patient to resist dealing with family issues (Baker, 1999).

Home or community-based alternatives to hospitalization usually result in better outcomes for diverse children and youth, while involuntary hospitalization tends to re-create past traumas of oppression (Herrera, 1996; Garrison, Roy, & Azar, 1999). If at all possible, out of home placement should be accomplished with the cooperation of the family and youth. An interagency approach within a system of care orientation is consistent with cultural competence since it uses community resources and empowers the child and family to a maximum extent (Koss-Chioino & Vargas, 1999).

The new science of ethnopsychopharmacology points to genetic and nutritional factors that contribute to differential pharmacological response across ethnic and racial groups. Genetic polymorphisms have been described for many drug-metabolizing enzymes in Causasian, Asian, and African-origin populations (Smith & Mendoza, 1996). Additionally, nutritional factors such as citrus and corn dietary content, which vary in different ethnic groups, inhibit the action of some of these enzymes. A higher prevalence of extrapyramidal symptoms from antipsychotics in African and Asian-origin populations may be related to metabolic differences (Zhang-Wong, Beiser, Zipursky, & Bean, 1998). Differences in hepatic aldehyde metabolism in American Indians and Asian Americans determine degree of intoxication from alcohol and related substances. Knowledge about substances of abuse and herbal remedies in diverse populations, and their interactions with medications, is also important (Smith & Mendoza, 1996).

There are also interpersonal aspects of pharmacotherapy with minority children and youth that require careful attention. These include proper informed consent and family collaboration, particularly

with traditional cultural family decision-makers (typically outside of the nuclear family); demystification of medications (not only education on their mechanisms of action, but also addressing suspicions about use for mind control and suppression of emotions); and empowerment of youth and families to make medication choices address perceived (and real) power differentials with clinicians.

Application of Cultural Competence Principles to Systems of Care

As outlined by Cross et al. (1989), there are four main qualities to be demonstrated by culturally competent agencies or institutions: valuing and adapting to cultural diversity; on-going organizational self-assessment; understanding and managing the dynamics of cultural difference; the institutionalization of cultural knowledge and skills through training, experience, and literature; and instituting service adaptations to better serve culturally diverse clients and their families.

Mental health services for minority and culturally diverse populations should be located in community settings where diverse populations feel comfortable accessing services. Services that are associated with institutions that are viewed favorably in the community, such as religious institutions, primary care settings, and non-medical settings such as schools, are often less threatening and more easily accessed than a traditional mental health clinic. Tertiary medical centers are venues of last resort for diverse populations, associated with death or involuntary long-term institutionalization. Reduced bureaucratic barriers and a personalized but respectful approach are important to facilitate access to services (Four Racial and Ethnic Panels, 1999).

Culturally competent practice can only occur within a system of care that has internalized and integrated cultural competence principles into every aspect of its organization and functioning. This requires an operationalization of how cultural competence is applied within these systems. Further impetus has been provided by the advent of managed care. Minority populations, particularly children, are widely covered under Medicaid, which is increasingly under state-sponsored managed care programs. Public managed behavioral health, combined with privatization, has adopted approaches that fail to address the multiple stressors faced by diverse children and families. It has also relocated many mental health services away from minority community settings, and selected against minority practitioners in provider panels due to fewer "formal" credentials and serving "higher-risk" inner-city or rural clients.

The response to these challenges has been to further operationalize the definition of culturally competent mental health services both at the provider and the systems level. This has led to the development of standards for culturally competent mental health services for mental health practitioners, provider organizations, health plans, and organized systems of care. Examples of such standards include the Center for Mental Health Services cultural competence standards (Four Racial/Ethnic Panels, 1999) and the cultural and linguistic standards of the U.S. Office of Minority Health (2000). These outline specific system standards (including governance, benefit design, quality assurance/improvement, information systems, and staff training and support) and clinical standards (access portals, triage and assessment, care planning, case management, treatment services, case management, and linguistic support). They outline cultural competence planning processes for systems of care based on needs assessments of diverse populations being served involving the leadership and front line providers.

Work in the area of cultural competence in children's mental health continues to evolve and develop as the fields of business, education, health care, and human services become aware of its importance to our multicultural society. The Surgeon General's supplement on mental health, culture, race, and ethnicity (U.S. Office of the Surgeon General, 2001) has further outlined significant issues in ethnic/racial mental health disparities and the need for expanding research in this important area. This report has complemented the Federal initiative on health disparities, which involves the identification inequalities not only in mental health status, but also in physical health. Research in epidemiology and services research examining mental health disparities for minority and underserved youth is also pointing the way towards the system of care reforms needed to improve the cultural competence of child mental health services.

However, as Cross et al. (1989) clearly asserted, the advancement of knowledge and skills needs to be matched with similar progress in attitudes in order for true progress towards a culturally pluralistic and proficient system of care. It will be up to us as front-line practitioners in community systems of care to use the new knowledge about the influence of culture, race, and ethnicity in mental health, but also face the old ugly specters of prejudice and discrimination that still affect all of us.

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