How to Become a Culturally and Linguistically Competent Health Care Provider

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The Culturally and Linguistically Competent Health Care Provider

Appreciating how responsive, culturally proficient communication and services can enhance the therapeutic alliance with patients and how quality health care can only occur within a patient's cultural context.

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Learning Objectives

- Define culture and cultural competence
- Appreciate the benefits of respectful communication; how providing responsive, culturally proficient care increases the therapeutic alliance
- Understand that quality health care can only occur within the patient's cultural context.
- Understand how ignoring diversity and culturally incongruent health care can adversely affect patient outcomes and compromise patient safety
- How lack of cultural competence can result in patient dissatisfaction.
- Learn how to eliminate misunderstandings in diagnosis and treatment planning that may result from differences in language or culture.
- Identify your counterproductive assumption or biases that will negatively contaminate your relationship with the patient.

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What is Culture?

- Culture refers to integrated patterns of behavior that includes the language, customs, attitudes, beliefs, values, religion/spirituality and institutions that unite a group of people.
- Culture is learned and transmitted in the family, includes an individualized world view, guides decision making and facilitates self-esteem and self-worth.
- Culture is a meaning making system; being culturally programmed to embrace a system which regulates one's behavior through honoring values, beliefs, customs, faith, rituals.
- Culture influences a patient's healthcare beliefs, practices attitudes toward care, and trust in the system and its providers.
- Cultural differences affect how health information and healthcare services are received, understood and acted on.

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What is Cultural Sensitivity?

- We see cultural sensitivity when neutral language is used in a way that reflects sensitivity and appreciation for the diversity we see in others.
- We convey it when words, phrases are intentionally avoided so an individual doesn't interpret them as impolite or offensive.
- We express it through behaviors that are polite and respectful.

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What is a Stereotype?

- Stereotyping is defined as a process by which people acquire and recall information about others based on sex, race, religion, etc.
- Prejudice is often associated with stereotyping and is defined as an unjustified negative attitude based on a person's group membership.
- It includes having an attitude, opinion or belief about a person.
- The beliefs/stereotypes expressed by those attitudes can contribute to disparities in health care.
- Stereotypes help us simplify the world and leads to social categorization.
- They are fixed and oversimplified images of people.
- They cause us to ignore differences about people.

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Definition of Cultural Humility

- Due to the increasing diversity of our world and the intermixing of different cultures, the importance of cultural competence in the professional world has become very important.
- Cultural humility is a humble and respectful attitude toward other cultures that pushes one to challenge their own cultural biases.
- You realize you cannot possibly know everything about other cultures, so you commit yourself to learning about other cultures as a lifelong process.

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Cultural Humility Principles

1. Lifelong commitment to learning and critical self-reflection
2. Desire to fix power imbalances within provider-client dynamic
3. Institutional accountability & mutual respectful partnership based on trust

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- The term "cultural humility" was introduced in 1998 as a dynamic and lifelong process of self-reflection and doing a self-analysis to identify your biases.
- You understand the value of being curious about other cultures and begin to educate yourself about these cultures.
- Cultural humility involves understanding the complexity of identities — that even in sameness there is difference — and that a clinician will never be fully competent about the evolving and dynamic nature of a patient's experiences.

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How to Develop Cultural Humility

- At its base, cultural humility means opening up a conversation in a way that genuinely attempts to understand a person's identities related to race and ethnicity, gender, sexual orientation, socioeconomic status, education, social needs, and others.
- An awareness of the self is central to the notion of cultural humility — who a person is informs how they see another.
- Awareness may stem from self-reflective questions such as:
  - Which parts of my identity am I aware of?
  - Which are most salient?

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- Which parts of my identity are privileged and/or marginalized?
- How does my sense of identity shift based on context and settings?
- What might be my own blind spots and biases?
- With this awareness, a provider can ask questions about how they receive the patient:
  - Who is this person?
  - How do I make sense of them?
  - What knowledge and awareness do I have about their culture?
  - What thoughts and feelings emerge from me about them?

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Cultural competence and cultural humility together

- A "culturally competent" provider needs to have knowledge and awareness of:
- health-related beliefs, practices, and cultural values of diverse populations;
- illness and diagnostic incidence and prevalence among culturally and ethnically diverse populations;
- treatment efficacy data (if any) of culturally and ethnically diverse populations.
- A provider operating with cultural humility must listen with interest and curiosity,
- Have an awareness of their own possible biases and attempt a non-judgmental stance about what they hear
- Recognize their possible inherent status of privilege as a provider and be willing to be taught by their patient

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Culture shapes appraisal of emotions

- We learn to recognize and experience emotions in certain ways.
- We don't all appraise emotions in the same way.
- Does threat always lead to fear?
- Does threat mean the same thing to all people?

- Appraisal gives meaning and it differs from culture to culture
- How groups appraise emotions depends on their values
- Example: Individualistic cultures foster more assertive and outspoken behavior
- In the West, shame is perceived as potentially damaging a relationship and in other cultures it is a sign of modesty.
- In the West, when we feel shame, we withdraw in silence and in other cultures, they reach out to others to repair the relationship.
- We learn prescriptive norms that include rules about when to have what emotions. What we call an emotion, how we regulate emotions

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Does Language Influence Thought?

- The Japanese tend to suppress and inhibit their emotions in the presence of others
- Americans display and express their emotions
- In the West we like high arousal; happy, elated, excited
- In the East, they value peaceful emotions, calmness, serenity and low arousal
- Sometimes culture influences words we use:
- Polish have no word for disgust
- Indonesians have no word for embarrassment
- Tahitians have no word for sadness

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What Does Cultural Awareness Mean?

It means being knowledgeable about one's thoughts and feelings and the ability to reflect on how these can affect one's interactions with others.

Why is Cultural Competence Important?

Culturally responsive services will provide a greater sense of safety from the patient's perspective, supporting the belief that culture is essential to healing.

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What Does Diversity Mean?

Diversity is an all inclusive concept that includes:

differences in race
ethnicity
immigration status such as refugee or immigrant
religion
age
gender
sexual orientation
ability/disability
socioeconomic status
occupation
spirituality
marital status

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What Does Cultural Competence Mean?

- Cultural competence or cultural proficiency is possessing the capability of effectively interacting with people from different cultures/race
- It is the attitudes, knowledge, skills necessary for providing quality care to diverse populations.
- Competence is an ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have a negative influence on another with a different worldview.
- The increasing diversity in the U.S. creates challenges on our health care delivery system to deliver culturally competent services that meet the social, cultural and linguistic needs of our patients.

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- One's values, beliefs, and ideas about health care and well-being are shaped by factors such as race, culture, ethnicity, language, gender, SES, physical and mental abilities, sexual orientation and occupation.
- Cultural Competence in health care is defined as the ability of providers and organizations to understand integrate these factors into the delivery of health care services.
- The goal of cultural competent health care services is to provide the highest quality care to every patient regardless of their race, culture and other variables.

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Are you aware that:

- 20% of people in the U.S. speak a language other than English at home
- The Latino population has grown by 43% in the U.S. between 2000 and 2010
- One out of two adult patients has difficulty understanding basic health information
- The average time it takes for a physician to interrupt a patient is in the first 20 seconds

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- Recent studies conducted by the U.S Department of Education and National Institute of Literacy reveal that 32 million adults cannot read.
- This is 14% of the adult population in the U.S.
- Racial and ethnic minorities are more likely to have lower levels of literacy due to cultural and language barriers and differing educational opportunities.
- Individuals with low literacy use more health care services.

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Cultural Competence is Ongoing

We develop cultural competence the more we increase our cultural knowledge.

Knowledge --→ Attitudes --→ Skills

- Knowledge: understanding the meaning of culture as a meaning making system
- Attitudes: respecting differences in culture
- Skills: knowing how to listen and respond – to elicit from the patient how they experience their illness

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How can culture impact the care I provide my patients?

Culture influences how one defines and experiences:

- Concepts of health; health care expectations
- Healing and treatment; who provides treatment, type of treatment
- What is considered a health problem
- How symptoms are expressed
- How illness, disease, and their causes are perceived
- The behaviors of patients who are seeking health care
- Attitudes toward health care providers

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Strategies for improving the patient/provider relationship include the following:

- Provide interpreter services
- Recruit and train minority staff
- Provide training to increase cultural awareness, knowledge, skills
- Incorporate culture specific attitudes and values into health promotion tools
- Include family in the health care decision process
- Culturally sensitive and competent health care should be integrated into existing academic/educational curriculum, lecture programs.

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What comes to mind when you are told you'll be seeing any of the following patients?

- Alzheimer's patient
- Teenager
- Asian male
- Black Male
- Indian female
- Welfare recipient
- Immigrant/Refugee
- Mentally ill individual
- 13 year old with a developmental disability
- Autistic child
- A gay individual

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Associations we make include:

- When we initially hear the profile of a patient, we all make associations and consider assumptions based on our past experience.
- We have a perception of the person before we ever meet them.
- We may harbor counterproductive assumptions or biases that may negatively influence our interactions
- Our patients make the same associations when they meet us.

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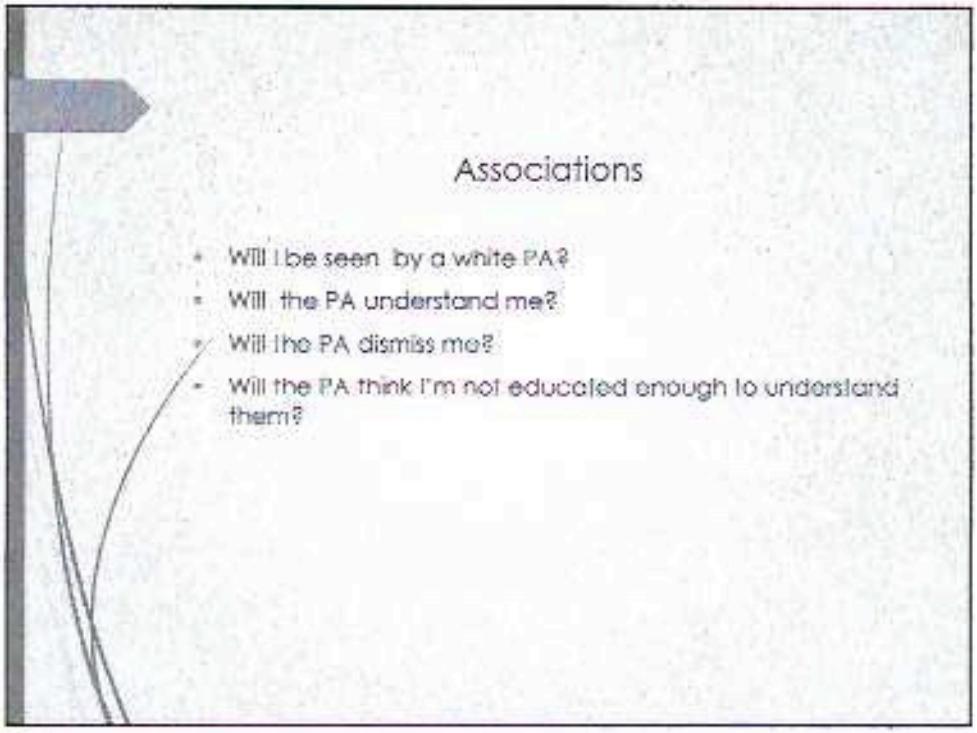
Associations
Will I be seen by a white PA?
Will the PA understand me?
Will the PA dismiss me?
Will the PA think I'm not educated enough to understand them?

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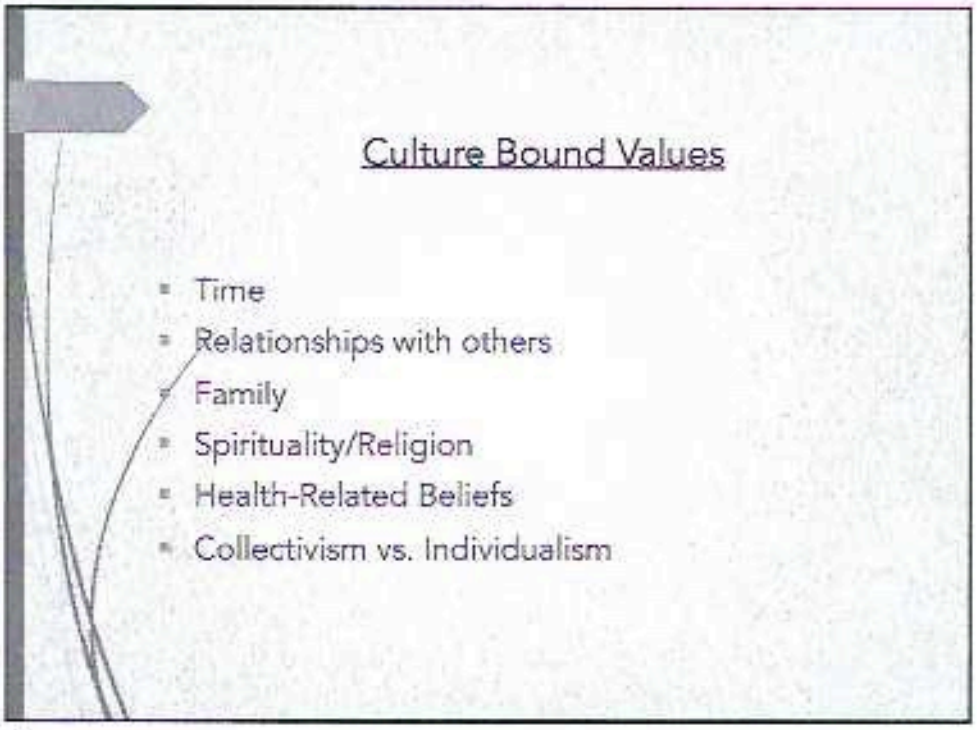
Culture Bound Values
Time
Relationships with others
Family
Spirituality/Religion
Health-Related Beliefs
Collectivism vs. Individualism

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Time Dimension- there are three ways in which people perceive time:

- The Past- traditions and ancestors play an important role in person's life
- The Present-little attention is paid to the past or future. Individuals are concerned with now
- The Future- Progress and change is highly valued
- In the West: time is precise and driven by a sense of urgency; other parts of the world time is fluid, stream like.

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Relationships With Others

Relationship with others: another aspect of a person's cultural value orientation. It can be categorized in three ways:

- Lineal relationship- refers to relationships that exist by virtue of heredity and kinship ties.
- Collateral relationship- focus primarily on group goals and family/us orientation; collectivists cultures such as Latino, Asian and Indian and individualist cultures such as in the West; nuclear family
- Individual relationship- refers to personal autonomy and independence; individual goals dominate in West and in other parts of world, people are interdependent such as in Latino, Indian and Asian cultures

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Family

Family remains the basic social unit. It is defined by individuals living together as a unit.

- Nuclear- husband, wife and children
- Single parent- either mother or father ant at least one child
- Extended family- may include grandparents, aunts, uncles, cousins and non-biologically related
- Blended-husband, wife and child/children from a previous
- Cohabitation- unmarried man and woman sharing a household with child/children
- Gay- same gender couple and child/children

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Spirituality and Religion

Spiritual/Religious Beliefs and Practices; an integral component of the individual's culture.

- May influence the person's explanation of the cause of illness, perception of its severity and choice of healer
- In time of crisis- may be a source of consolation
- In health care situations-people frequently search for a spiritual explanation for illness and disability

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Studies reveal that racial and ethnic minorities have higher morbidity and mortality rates from chronic diseases.

A higher proportion of African Americans and Latinos, compared to Whites report experiencing one of the following chronic conditions:

1) Asthma
2) Diabetes
3) Anxiety Disorders
4) Cancer
5) Hypertension
6) Mood Disorders
7) Heart Disease
8) Obesity

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Individuals with chronic conditions seek more health care services which increases their interaction with you.

If you and your agency do not provide culturally competent care, it's more likely patients will have more negative health consequences and be dissatisfied with their care.

The quality of patient/health care provider interactions is lower among Non-White patients, especially among Latinos and Asian Americans.

African Americans, Latinos and Asian Americans believe they would receive better care if they belonged to a different race or ethnicity.

Minorities report feeling they were treated disrespectfully, ignored or talked down to by their health care provider.

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The Benefits of Respectful Communication

- Reducing the risk of having a patient file a malpractice suit
- Improve safety and adherence
- Improve the patient's office experience
- Improve health care provider and patient satisfaction

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Active Listening:

An approach that focuses on inquiry, analysis and reflection throughout the care process is foundational.

In addition, being curious, empathetic, respectful and showing humility will aid in the initial interaction between health care provider and the patient.

Remember: we begin every human interaction with guarded trust.

The goal is to move it to a more fuller trust with time.

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ACTIVE LISTENING: A skill that requires practice

- Listening and understanding (clarifying)
- Empathy: the ability to take the role of the other.
- For example: asking the patient "What is it like to be you?"
- Asking and encouraging (probing questions)
- Paraphrasing and Summarizing
- Remember, you cannot force others to trust or respect you
- Only your actions reveal to others you are worthy of being trusted and respected

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Ask Open Ended Questions/Statements

Responses that require more than a "yes" or a "no"

- "What else?" "How?" "When?
- "Tell me more about..."
- "I'd like to hear more....."

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What Doesn't Help:

"Why?"

Feels accusatory, creates defensiveness.

"You Should"

A judgmental (advice giving) statement.

Implies a superiority of the advice giver and may cause the receiver to feel inadequate.

"You Shouldn't"

Implies the person is making poor choices.

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- Building trust and respect results in the patient sharing more.
- You must be willing to listen genuinely.
- Ask open ended questions.
- Demonstrate the ability to ask open ended questions during history taking
- Avoid assumptions which are counterproductive
- Knowing how your cultural values, assumptions and beliefs affect patient care and clinical decision making.

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Best Practices: General Guidelines/Questions to Ask Your Patient

- These questions help explore how patients view their condition/behavioral health concerns:
- I know that patients and health care professionals sometimes have different ideas about illness and diseases, so can you tell me about your idea of your problem?
- How do you feel about your problem? Do you think it is a serious problem?
- What do you think caused your problem?
- Why do you think it started when it did?
- What is going on in your body and mind as a result of this problem?

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- How has this problem affected your life?
- What frightens or concerns you most about this problem and its treatment?
- How is your problem viewed by your family?
- How is your problem viewed by your community?
- How does your problem affect your status in your community?
- What kinds of treatment do you think will help you?

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Questions for Health Care Provider to Consider

1) What does the patient attribute their illness to?
2) What are the patient's cultural beliefs about his/her illness?
3) What name does the patient give his/her illness?
4) What does the patient think promotes health?
5) What is the patient's religious affiliation and how active is he/she in practicing his/her faith?
6) Does the patient use cultural/spiritual healers?
7) Who determines if the patient is sick or healthy?
8) What kinds of cultural healing practices does the patient engage in?
9) How does the patient's culture view mental illness?

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Determine if there are any language barriers.

Ascertain whether the patient speaks English or not, their native dialect, and the degree of acculturation.

- Allow sufficient time for interviews. Be patient. Translation often takes extra time.
- It may also take time for some patients to feel comfortable in sharing very intimate, personal information with outsiders.
- Promotion of educational resources about mental health.
- Increase the patient's and/or community's awareness of mental health and, more specifically, Asian, Indian, African mental health via promotion of available resources—in English and their languages.

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Inquire about traditional beliefs.

- Ask about traditional beliefs to gather any information on how these beliefs can influence an individual's expression of mental distress and their preferred methods of treating mental health disorders.
- For example, some non-English speaking or unacculturated Asian Americans hold traditional values and concepts of health and disease (e.g., Yin/Yang) that may influence them to express mental distress through somatic symptoms.
- Some may also seek traditional healers such as acupuncturists and herbalists to treat health and mental health disorders.
- Incorporation of traditional interventions:
- When appropriate—culturally and individually—consider traditional practices.
- This includes, if indicated, diets, exercises, and other traditional methods used to reduce stress and increase relaxation, such as Yoga, Tai-Chi, breathing exercises, etc.

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How to Improve Cultural Knowledge of Health, Illness and Healing

- These questions can help facilitate understanding of your patient's condition:
- Does the cultural group in question consider psychological, physical and spiritual health or well being as separate entities or as unified aspects of the whole person?
- How are illnesses and healing practices defined and conceptualized?
- What are acceptable behaviors for managing stress?
- How do people who belong to the culture typically express emotions and emotional distress?
- What behaviors, practices or customs do members of this culture consider to be preventive?
- What words do people from this culture use to describe a particular problem?
- How do members of the group explain the causes of a particular condition?

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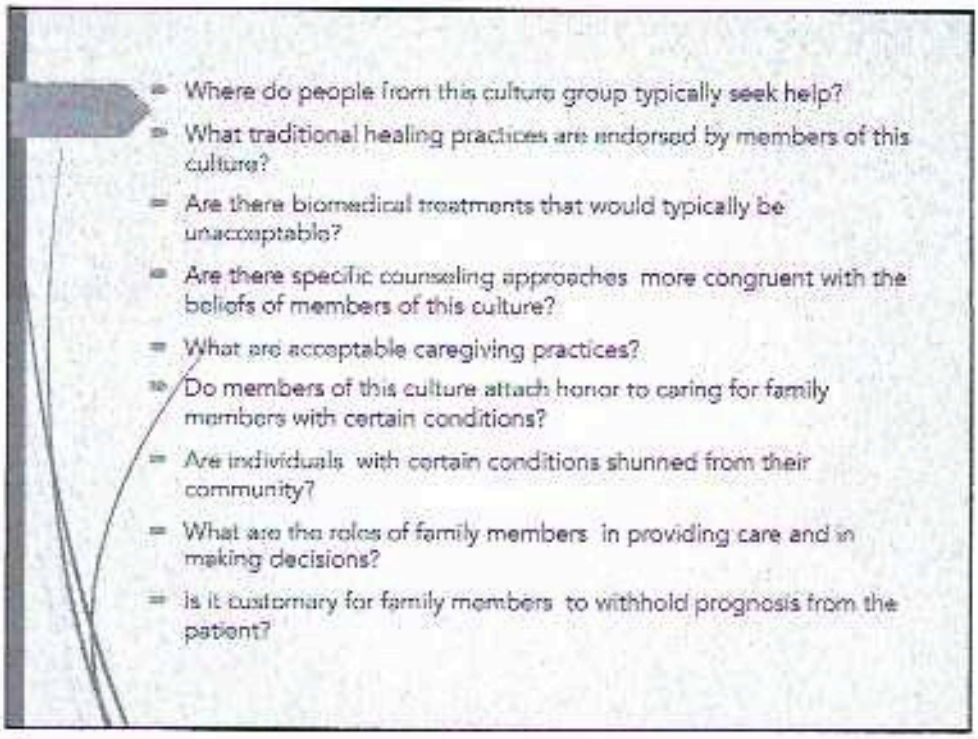
Where do people from this culture group typically seek help?
What traditional healing practices are endorsed by members of this culture?
Are there biomedical treatments that would typically be unacceptable?
Are there specific counseling approaches more congruent with the beliefs of members of this culture?
What are acceptable caregiving practices?
Do members of this culture attach honor to caring for family members with certain conditions?
Are individuals with certain conditions shunned from their community?
What are the roles of family members in providing care and in making decisions?
Is it customary for family members to withhold prognosis from the patient?

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Attitudes and Behaviors of Culturally Competent Counselors

Sensitivity

- Understanding the client's experiences of racism, stereotyping, and discrimination
- Exploring the client's cultural identity and what it means to her/him
- Actively involving oneself with individuals from diverse backgrounds outside the counseling setting to foster a perspective that is more than academic or work related
- Adopting a broader view of family and, when appropriate, including other family or community members in the treatment process
- Tailoring treatment to meet the cultural needs of the client (e.g., providing outside resources for traditional healing)

Respect

- Exploring, acknowledging, and validating the client's worldview
- Approaching treatment as a collaborative process
- Investing time to understand the client's expectations of treatment
- Using consultation, literature, and training to understand culturally specific behaviors that demonstrate respect for the client
- Communicating in the client's preferred language

Commitment to Equality

- Proactively addressing racism or bias as it occurs in treatment (e.g., pro- cessing derogatory comments made by another client in a group counseling session)
- Identifying the specific barriers to treatment engagement and retention among the populations being served
- Recognizing that equality of treatment does not translate to equity—that equity is defined as equality in opportunity, access, and outcome (Srivastava 2007)
- Endorsing counseling strategies and treatment approaches that match the unmet needs of diverse populations to ensure treatment engagement, retention, and positive outcomes

Humility

- Recognizing that the client's trust is earned through consistent and compe- tent behavior rather than the potential status and power that is ascribed to the role of counselor
- Acknowledging the limits of one's competencies and expertise and referring clients to a more appropriate counselor or service when necessary
- Seeking consultation, clinical supervision, and training to expand cultural knowledge and cultural competence in counseling skills
- Seeking to understand oneself as influenced by ethnicity and cultural groups and actively seeking a nonracist identity
- Being sensitive to the power differential between client and counselor

Flexibility

- Using a variety of verbal and nonverbal responses, approaches, or styles to suit the cultural context of the client
- Accommodating different learning styles in treatment approaches (e.g., the use of role-plays or experiential activities to demonstrate coping skills or al- cohol and drug refusal skills)
- Using cultural, socioeconomic, environmental, and political contextual factors in conducting evaluations
- Integrating cultural practices as treatment strategies (e.g., Alaska Native traditional practices, such as tundra walking and sustenance activities)

Openness

Recognizing the value of traditional healing and help-seeking practices

Developing alliances and relationships with traditional practitioners

- Seeking consultation with traditional healers and religious and spiritual leaders

when appropriate

- Understanding and accepting that persons from diverse cultural groups can

use different cognitive styles (e.g., placing more attention on reflecting and processing than on content; being task oriented)

How To Improve Cultural Knowledge of Health, Illness, and Healing

To promote culturally responsive services, counselors need to acquire cultural knowledge regarding concepts of health, illness, and healing. The following questions highlight many of the culturally related issues that are prevalent in and pertinent to assessment, treatment planning, and case management. This list of considerations can help facilitate discussions in counseling and clinical supervision contexts:

- Does the cultural group in question consider psychological, physical, and spiritual health or well- being as separate entities or as unified aspects of the whole person?
- How are illnesses and healing practices defined and conceptualized?
- What are acceptable behaviors for managing stress?
- How do people who belong to the culture in question typically express emotions and emotional distress?
- What behaviors, practices, or customs do members of this culture consider to be preventive?
- What words do people from this cultural group use to describe a particular problem?
- How do members of the group explain the origins or causes of a particular condition?
- Are there culturally specific conditions or cultural concepts of distress?
- Are there specific biological and physiological variations among members of this population?
- What are the common symptoms that lead to misdiagnosis within this population?
- Where do people from this cultural group typically seek help?
- What traditional healing practices and treatments are endorsed by members of this group?
- Are there biomedical treatments or procedures that would typically be unacceptable?
- Are there specific counseling approaches more congruent with the beliefs of most members?
- What are common health inequities, including social determinants of health, for this population?
- What are acceptable caregiving practices?
- Do members of this group attach honor to caring for family members with specific diseases?
- Are individuals with specific conditions shunned from the community?
- What are the roles of family members in providing health care and in making decisions?
- Is discussing consequences of and prognosis for behaviors, conditions, or diseases acceptable?

  Is it customary for family members to withhold prognosis from the client?

Table 3. Phrases to Help Elicit the Patient's Perspective

Areas of focus	*Suggested phrases*
Feelings	"How did that make you feel [emotionally]?"
	"Tell me more about what was worrying you."
	"What were your emotions at that time?"
	"What would you say is worrying you the most?"
	"How do you feel about that?"
	"What was that like [emotionally]?"
Ideas	"What do you think is the cause of...?"
	"Do you have any thoughts on what might be causing this?"
Concerns	"What do you worry about regarding your health?"
	"Is there something you worry might happen?"
	"What are your fears about...?"
Impact	"How has your illness affected your daily life?"
	"What difficulties are you facing because of your illness?"
Expectations	"What would you like to get out of today's visit?"
	"What more can I do for you today?"
	"Is there anything else you need from us today?"

Table 4. Techniques for Expressing Empathy to Patients

Technique	*Examples (may overlap)*
Naming	"It seems like you are feeling..."
	"I wonder if you are feeling..."
	"Some people would feel... in this situation."
	"I can see that this makes you feel..."
Understanding	"I can understand how that might upset you."
	"I can understand why you would be... given what you are going through."
	"I can imagine what that would feel like."
	"I can't imagine what that would feel like!"
	"I know someone who had a similar experience. It is not easy."
	"This has been a hard time for you."
	"That makes sense to me."
Respecting	"It must be a lot of stress to deal with..."
	"I respect your courage to keep a positive attitude in spite of your difficulties."
	"You are a brave person."
	"I am impressed by how well you handled this."
	"It sounds like a lot to deal with."
	"You have been through a lot."
	"You did the right thing by coming in."
Supporting	"I want to help in any way I can."
	"Please let me know if there is anything I can do to help."
	"I am here to help you in any way I can."
	"I will be with you in this difficult time."
	"I will be with you all the way."

Exploring	"Tell me more about what you were feeling when you were sick." "How are you coping with this?" "What has happened since we last met?"

Information from reference 10.

Rating System for Interviewing Mental Health Cases

As a PA your interviewing skills can influence the patient's perception of you and how they experience their illness. Successfully interviewing patients from diverse cultures requires you to understand different communication patterns, family dynamics and related factors such as etiology of their mental health conditions, traditional healing practices and how disclosing illnesses may invite shame on the family.

Under each item – please rate how effectively the PA student displayed the skill:

Rating: 1: Fair 2: Good 3: Very Good 4: Excellent

Please evaluate to what extent the PA inquired into these areas:

1) Active listening with empathy and understanding the patient's perception of his/her problem. The patient is encouraged by PA to tell their "story." PA asked patient tell me what it is like being you? Why do you think this problem started now? Have you discussed this with you friends/family? What do they think?

Rating: _____

2) The PA explaining his/her perception and understanding of the problem to the patient. Rating: _____

3) The PA acknowledging and discussing the patient's condition with him/her. Rating: _____

4) The PA recommending treatment based on his/her best understanding of the patient's problem. Also – discussing complementary and nontraditional approaches with the patient.

Rating: _____

5) The PA discussed with the patient his/her religious and spiritual beliefs because this can influence the patient's views about health care, etiology and the meaning of their illness, and the appropriateness of medical procedures.

Rating: ___

6) The PA asked the patient if they have sought help from alternative or folk healers, friends, or other people who are not doctors for help with their condition. Asking if it helped.

Rating: _____

7) PA asking probing question such as: How best do you think I can help you? How can we work together on this? Try to find options that will be mutually acceptable to you and your patient and that do not contradict but rather incorporate the patient's beliefs into treatment.

Rating: _____

8) Autonomy, authority and family dynamics: Did the PA consider the following:

Although patient autonomy is a core ethical principle in the practice of medicine, you must also recognize the fact that the way people make decisions is influenced by their family relationships, their cultural backgrounds, and other factors. What is the role of the family in patients' medical decision making process? What is the role of their community and spiritual leaders in their decisions? Attitudes toward allopathic medicine.

Rating: _____

9) Negotiate a treatment plan that is acceptable to both yourself and your patient. Although this may not, from your perspective, be the optimal plan, it is important that whatever plan you agree on is both acceptable and meaningful to the patient:

Rating: ____

Overall Rating: 32-36 ---→ Excellent 26-31---→ Very Good 20 – 25 ---→ Good TOTAL: _____

Additional Notes:

Case #1: Vietnamese

Dung Nguyen is a 22 year old Vietnamese male you'll be seeing in your office. He attends UCLA and just graduated with a BS in Chemical Engineering. Despite feeling great about graduating, he comes to you concerned about hearing a voice he suspects is an ancestor that haunts him for his uncle's past transgressions. He sometimes also sees a visual hallucination of a ghost in his dorm room on campus. Dung reports he sometimes sees the Buddha in his room. He is terrified of disclosing any of this to his family who lives in Los Angeles. He is now prepared to leave UCLA, move home and search for a job but feels frozen in place and is delaying his move home with his parents and siblings. He's not sure what to do now.

Case #2: Nigerian

Mary is a 24 year old Nigerian who has been in the U.S for 10 years after her family arrived in Los Angeles. She currently lives at home with her parents and siblings. Mary is a CNA working full time in a skilled nursing facility in Los Angeles and she enjoys her job. She comes to see you complaining of insomnia, poor appetite, body aches and difficulty concentrating. She lacks energy and has a difficult time arising in the morning to go to work. Mary believes these recent changes are attributed to supernatural forces and wants you to help her find a prayer camp like they have back home in Nigeria. She describes the prayer camp as a retreat where people afflicted with these conditions go and where they're chained to trees and prayed for.

Case #3: Indian

Mandar is a 23 year old Indian attending University of Massachusetts at Amherst and is a year away from earning his BA in psychology. He wants to apply to social work school and this has been his dream for several years now. You are seeing Mandar for his first appointment in your primary care clinic, and he shares that recently he's not been sleeping well, losing pleasure in activities, has a poor appetite, feeling lethargic and having difficulty concentrating. Mandar says he's not showering, practicing his hygiene and a few weeks ago he began feeling hopeless about his future; feeling like he won't ever get admitted to graduate school in social work. He thinks this recent change in his life is due to him being less self-disciplined, a weaker will power and a supernatural cause such as evil spirits invading his mind.

Case Study #1

Chung is a 28 year old male who came to the U.S. from China nine months ago with the hope of attaining financial security and bringing his family to the United States. He comes to see you at your primary care clinic with a nine month history of fatigue, appetite loss, sleep disturbance, difficulty concentrating and feeling hopeless about his future or prospects of bringing his family to the U.S. He reports headaches, losing weight recently, stomach upset and pain in his arms and legs. Chung is no longer interested in activities that brought him pleasure about a year ago. He has been working as a waiter in a restaurant for 12 hours a day, six days a week since his arrival. He attributes his symptoms to long working hours.

The findings of a physical examination and all laboratory results; complete blood cell count, serum electrolytes, thyroid function tests, liver function tests are unremarkable.

As a primary care professional how could you gain his trust and confidence in you; respond empathetically and begin to explain to Chung that his depression is a mental health condition and not a weakness or him being a moral failure.

Please write thoughtfully in one to two pages, one inch margins, 12 point font

Thank you – Elie Please email your paper to me at: elijahlevy@scuhs.edu

Factors to consider in your response to this case:

Due to cultural bias and stigma, Asians tend to view depression as a personal weakness or moral failing.

Remember – Asians may under-report their emotional symptoms for fear of feeling ashamed and humiliating their family.

The tendency for Asian patients is to somaticize their symptoms by expressing physical discomfort.

Also – Asians tend to view the mind and body as one rather than a dualistic view where mind and body are two distinct entities.

Standardized Patient #1: Chinese

Yihan is a 26-year old Chinese female who has been in the U.S. for three years as a student. She's performing very well academically at U.C. Irvine but lately has been experiencing auditory and visual hallucinations. She struggles to ignore the voices which are devaluing -- saying she's worthless and will never graduate and earn her degree because she's incompetent and stupid. Yihan also sees a ghost in her room before falling asleep. You suspect she may meet criteria for Schizophrenia. Yihan lives at home with her parents and last week, she disclosed to her family that she's hearing voices and suspects classmates are spreading rumors about her failing grades and that the campus police are doing surveillance on her. Her parents believe that spiritual and mystical forces invaded her mind and that Yihan did things that upset her social harmony or she transgressed and violated some social norms of her culture. They plan to send her to a shamanistic healer, Buddhist monk or someone that practices traditional Chinese medicine. The parents are not considering sending her to a mental health practitioner.

The findings of a physical examination and all laboratory results; complete blood cell count, serum electrolytes, thyroid function tests, liver function tests are unremarkable.

As a primary care professional how could you gain her trust and confidence in you; respond empathetically and begin to explain to Yihan that her condition is a mental illness and not a weakness or her violating social harmony or norms.

Factors to consider in your response to this case:

Due to cultural bias and stigma, Asians tend to view mental illness as a personal weakness or moral failing.

Remember -- Asians may under-report their symptoms for fear of feeling ashamed and humiliating their family.

Also – Asians tend to view the mind and body as one rather than a dualistic view where mind and body are two distinct entities.

Standardized Patient #2: Indian

Arjun is a 28 year old Indian male living alone in his apartment in Long Beach. His family is in India and he's been here for about five years working as a web designer at a consulting company in Long Beach. He enjoys his work but lately has been lethargic, experiencing sleeping problems, a poor appetite, impaired concentration and is beginning to feel hopeless about his future in America. Arjun is reluctant to call and talk to his family about this recent change in his functioning because he knows they will feel shamed and it will stain his family's reputation. In addition, he's worried his family will perceive his as weak and fundamentally flawed. Arjun also knows his family will attribute his depression to an outside force invading his mind and his lack of discipline to honor his family's values and ideals for a good life. Arjun is also worried that his parents and friends back home will perceive him as being punished for his past misdeeds. He is worried that if he discloses these things to his family they will insist he come back home so they can have him seen by a spiritual adviser and folk doctor.

The findings of a physical examination and all laboratory results; complete blood cell count, serum electrolytes, thyroid function tests, liver function tests are unremarkable.

As a primary care professional how could you gain his trust and confidence in you; respond empathetically and begin to explain to Arjun that his condition is a mental illness and not a weakness and that he's not being punished for past misdeeds.

Factors to consider in your response to this case:

Due to cultural bias and stigma, Indians tend to view depression as a personal weakness or an evil force invading his body.

Others will attribute the illness to the person lacking will power and lacking self-discipline.

Indians may under-report their symptoms for fear of feeling ashamed and humiliating their family. Further -- others will perceive them as dangerous and unpredictable.

Standardized Patient #3: African (Nigerian)

Abeo is a 21 year old Nigerian male attending UCLA working on his undergraduate degree in Biology. He intends to apply to medical school in two years and is excited about graduating in a year. Abeo lives at home and plans to find part time work transporting patients in a hospital to gain some experience after he graduates. However, he's recently been experiencing anxiety symptoms including not wanting to be around his friends, worrying about his parent's health, his own health and lots of doubt about his ability to get admitted to medical school. Abeo is also not sleeping well and has recently been having headaches, poor concentration and fatigue. He's noticed his grades are slipping and he's been worrying excessively about this issue. Abeo thinks he caused these symptoms because he's misbehaved and he feels shameful and guilty. He knows that if he discloses this condition to his parents, they will insist on him seeing a spiritual or religious healer (priest) to remove the supernatural forces that caused him this condition. In the past his parents have indicated that when anyone gets sick, they believe it represents a sickness of the soul and a burdened heart. Abeo would like to be screened and evaluated at the school's health center before he discloses his condition to his parents. He would like to discuss this situation with you and get your advice.

The findings of a physical examination and all laboratory results; complete blood cell count, serum electrolytes, thyroid function tests, liver function tests are unremarkable.

As a primary care professional how could you gain Abeo's trust and confidence in you; respond empathetically and begin to explain to him that his anxiety symptoms were not caused by a supernatural force and that he shouldn't feel shameful and guilty about it.

Factors to consider in your response to this case:

Remember -- Africans may under-report their symptoms for fear of feeling ashamed and humiliating their family.

His friends and family may shun and exclude him from activities once they learn of his mental illness.

Friends and family will say forces put a spiritual curse on Abeo or he was bewitched

Patient Centered Interviewing

1

Characteristics of Patient Centered Interviewing

- Focuses on disease and illness experience rather than exclusively on disease process
- Allows patients to express what is most important to them.
- Recognizes and promotes self sufficiency, responsibility and autonomy of patients.
- Uses open-ended questions to elicit patient's perspective on illness, treatment and other psychosocial issues.
- Tailors questions, terminology and counseling based on the individual patient's context and circumstances.
- Demonstrates empathy and a non judgmental attitude by the healer toward the patient's experiences.
- Allows patient and provider to collaborate and compromise on the meaning of symptoms, etiology of illness, goals of treatment and different treatment options.
- Provides opportunities for disease prevention and health promotion.

2

Patient centered interviewing is associated with the following:

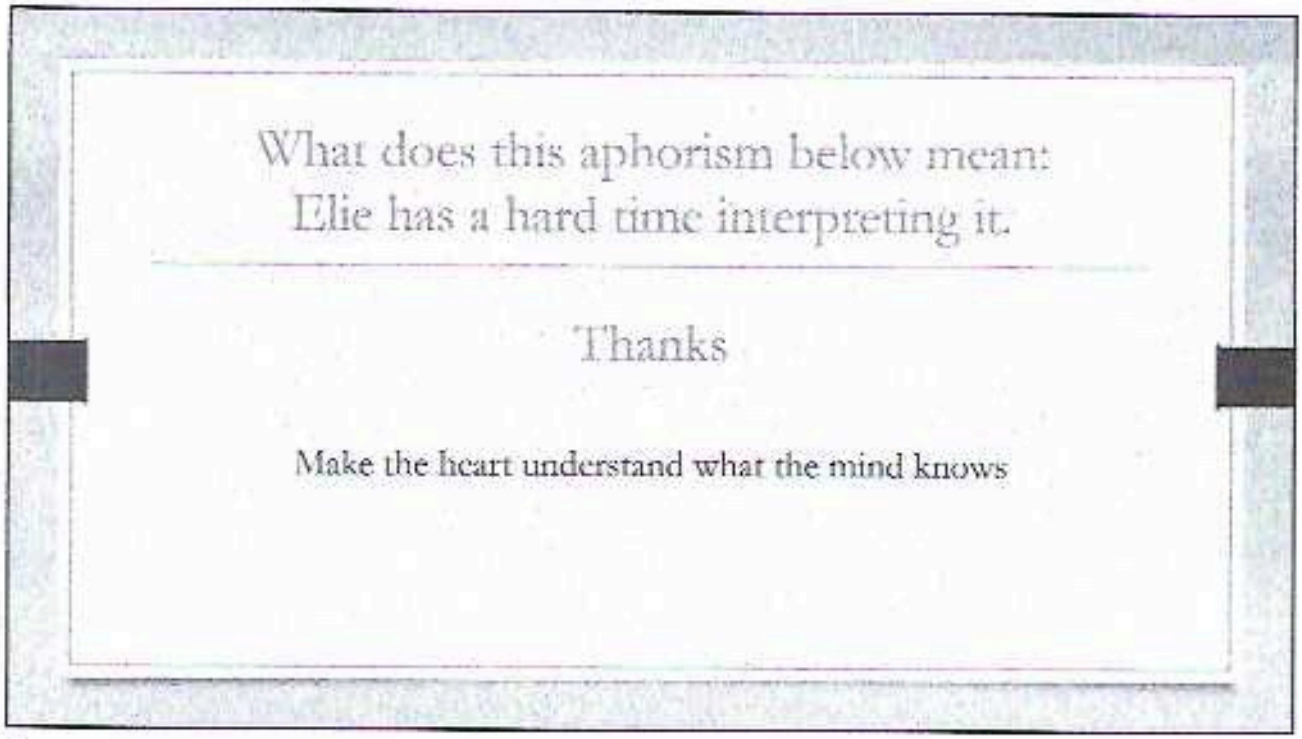
- Greater patient satisfaction with their provider and the clinical care received.
- Improved patient adherence with treatment.
- Better patient recall, understanding, and knowledge of information discussed during clinical encounters.
- Better health outcomes related to diabetes, hypertension, cancer, post operative recovery, and other conditions.

3

Examples of questions that can help you explore the meaning of the illness from the patient's perspective include the following:

- What do you think has caused your problem? How?
- Why do you think it started when it did?
- How does it affect you?
- What worries you the most?
- What kinds of treatment do you think you should receive?
- Why did you decide to come in for this problem now?

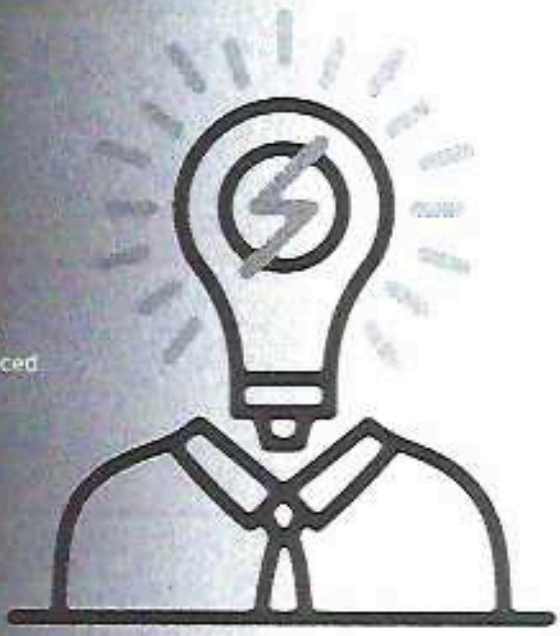
4


What does this aphorism below mean:
Elie has a hard time interpreting it.
Thanks
Make the heart understand what the mind knows

5

Implicit Bias

The term implicit bias was first coined in 1995 by psychologists Mahzarin Banaji and Anthony Greenwald, where they argued that social behavior is largely influenced by unconscious associations and judgments.



1

- Implicit biases are unconscious attitudes and stereotypes that are revealed in various domains such as in criminal justice, employment setting, healthcare, race, socioeconomic status, gender, sexuality.
- Implicit bias is synonymous with unconscious bias.
- Some of these biases are the outcome of our brain attempting to identify consistent patterns of behavior in others; relieving us of having to deal with a complex world.
- We may act on our implicit biases, attitudes and preferences and not realize we've treated the individual in a disrespectful, discriminatory way.

2

Understanding Unconscious Bias

https://www.youtube.com/watch?v=dVp9Z5k0dEE&t=12s

3

Kahneman (2011) distinguishes between two types of thinking: system 1 and system 2.

System 1 is the brain's fast, emotional, unconscious thinking mode.

Implicit biases are examples of System 1 Thinking

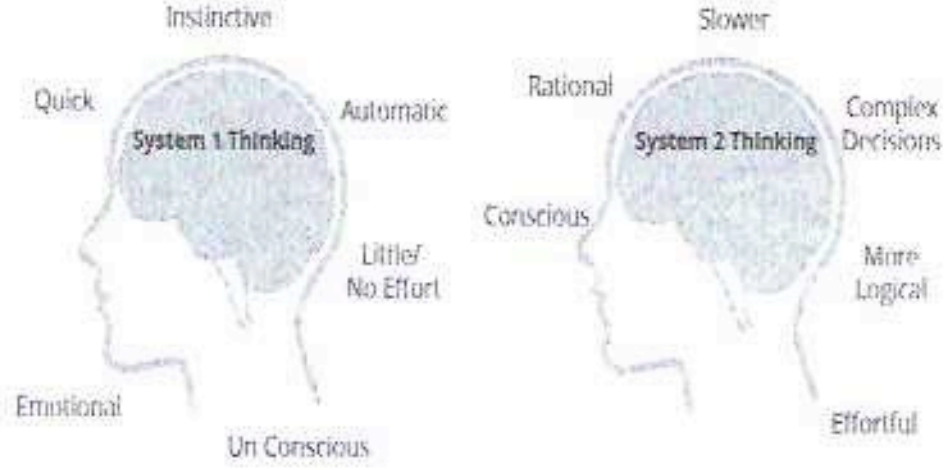
This type of thinking requires little effort, but it is often error prone.

Most everyday activities (like driving, talking, cleaning, etc.) make heavy use of the type 1 system.

The type 2 system is slow, logical, effortful, conscious thought, where reason dominates.

4

DANIEL KAHNEMAN'S SYSTEMS OF THINKING



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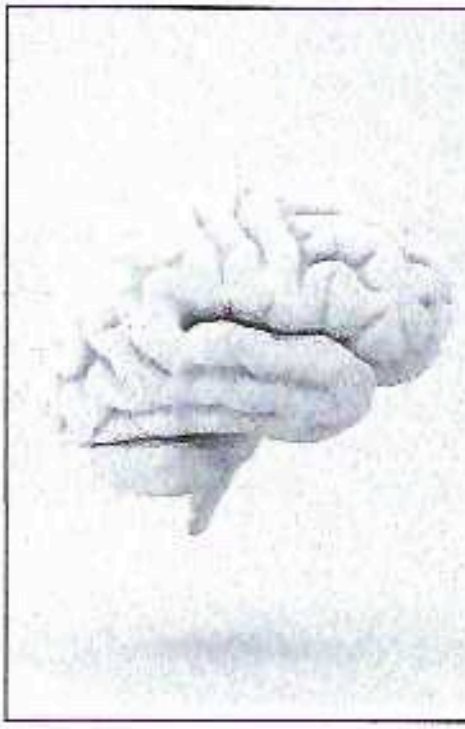


We Like to Take Mental Shortcuts

Implicit biases can be perceived as taking cognitive shortcuts.

Our urgency driven and hurried society creates stress in our lives and leaves us susceptible to using biases to sort/filter all the overwhelming data.

In general we all search for strategies to simplify our world.

In the end, we tend to act on our biases, using them as a theory to navigate through our complex world.

6

Causes of Implicit Bias

We're likely create biases because of tendencies to create patterns

- Our brains have a natural tendency to seek patterns and associations to make sense of a very complicated world.
- Studies reveal that before kindergarten, children rely on their group membership (e.g., racial group, gender group, age group, etc.) to guide perceptions about others.
- Children establish patterns and recognize what distinguishes them from others.
- Children may conclude that "what is similar to me is good, and what is different from me is bad"
- Perceiving how you are different than others may result in forming negative perceptions of the outgroups resulting in implicit biases.

7

What Are the Implications of Unconscious Bias?

- We see implicit biases emerge in many sectors of society.
- Our daily interactions may contain implicit biases.
- This occurs when certain actions (or microaggressions) make others feel uncomfortable or aware of the specific prejudices you may hold against them.

Racial Stereotypes

- Implicit bias can be expressed as unconscious racial stereotypes.
- One may not be aware they harbor an automatic preference for one race over another.

8

WHAT IS IMPLICIT BIAS IN HEALTHCARE?

- Implicit bias can influence how health care providers interact with patients.
- In September 2020, the Regenstrief Institute published data from the Department of Veterans Affairs (VA) revealing that veterans seeking mental health treatment sensed non-verbal cues that showed implicit bias.
- The survey of 85 Black veterans showed that most had good patient-provider relationships, but many sensed that race could play a role in their healthcare.
- "They explained that structural characteristics such as the physical space of an institution project how welcoming an institution might be to minority patients, and that staff diversity, especially in position of power, reflects the facility's values and culture related to racial equity"
- Some patients reported feeling stereotyped by mental health providers; that clinicians were distant.
- Some participants also shared that because of their physical appearance, they felt stereotyped as angry, big Black men
- They explained that some providers viewed them as a physical threat and react fearfully.
- Racial and ethnic minorities; women are more likely to receive an inaccurate diagnosis, fewer treatment options and poorer clinical outcomes.
- Black children may receive suboptimal care compared to White children.

9

How does implicit bias influence health care?

https://www.youtube.com/watch?v=ze7Fff2YKfM&t=34s

10

- We should always receive good healthcare, regardless of personal characteristics, identities, or traits such as race or gender.
- Undoubtedly, implicit biases surface healthcare and they can negatively affect the quality of healthcare one receives.
- Health care providers strive to provide impartial care to their patients.
- However, we know a percentage of patients receive differing quality of healthcare resulting from biases of their health care providers.

11

- Biases can lead to arriving at an inaccurate diagnosis, delays in treatment and related procedures.
- Delays in treatment can produce additional worry and stress on the patient.
- Implicit bias can have adverse consequences on:
  - patient experience, health outcome

A patient may sense a provider's implicit bias and may be less motivated to develop a meaningful relationship with their provider.

12

Gender Stereotypes

- Gender biases seem to be a common form of implicit bias.
- Gender biases are products of how we perceive men and women based on traditional feminine and masculine traits and characteristics.
- For example, we tend to assign fame more often to males than females.
- In academia, females are more likely to be perceived as having stronger language skills than math, and males are more likely stronger in math than language skills.
- This bias may influence one's career ambitions/jobs.

13

Racial Groups

- In 2019 National Healthcare and Disparities Report found that white patients were more likely to receive better quality care than:
- Black patients
- Native American patients
- Alaska Native patients
- Hispanic patients
- Native Hawaiian/Pacific Islander patients
- A person of color may have delays in treatment, leading to poorer outcomes.

In 2016 a study revealed that some physicians were significantly more likely to recommend white patients for bypass surgery than Black patients.

This conclusion was attributed to the physicians' belief that their Black patients were less educated and therefore not follow through with their post-operative treatment.

14

Socioeconomic Status

Studies suggest that some physicians may think that people from low socioeconomic backgrounds are:

- Less intelligent
- Less independent
- Less responsible
- Not likely to comply with treatment protocols and keep follow up appointments.

- Studies also suggest that some physicians were more likely to delay testing and not make referrals for specialty treatments among patients from low socioeconomic statuses.

15

LGBTQ+ Community Bias

- People may hold implicit biases against members of the LGBTQ+ community.
- Remember — these biases are unconscious.
- Example: Asking a female friend if she has a boyfriend, assuming her sexuality is heterosexual.
- One could just ask if she is seeing someone.

16

Work

- Implicit biases can also be revealed in the workplace.
- One study examined who received more calls for interviews based on stereotypical Black and White names.
- Whites received 50% more calls for interviews than applicants with stereotypical Black names.
- We refer to this phenomenon as a form of hiring bias.
- Anglicized named applicants can be expected to receive calls for interviews compared to ethnic named applicants.

17

Social and Cultural Influences

The media, culture and one's rearing/socialization experiences can create implicit associations we form.

- Social media can influence development of implicit biases.
- Television, journal articles and magazines can also produce implicit biases.
- Some may associate minorities with criminal behavior, gang involvement and other deviant activities.
- Studies have documented that racial attitudes of parents influence their children's development of prejudicial attitudes.

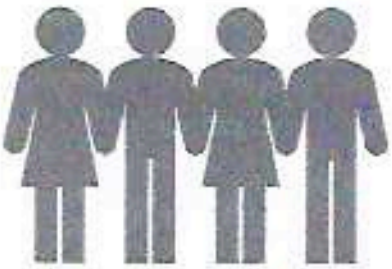
18

Education is crucial.

- Understanding what represents implicit biases, how they emerge and how to recognize them in ourselves is critical in their removal.
- Increasing our knowledge of other cultures, our language and how our actions can be offensive is critical.
- Education is a powerful tool; we can educate through books, print and social media, advocacy.
- Organizations must work to remove health disparities by offering training on implicit bias and cultural competency.

19

Influence of Culture on Development



1

Culture is a shared system of meaning, which includes values, beliefs, and assumptions expressed in daily interactions of individuals within a group through a definite pattern of language, behavior, customs, attitudes, and practices.

- Cultural background gives children a sense of who they are.
- These agents influence emotional, social, physical and linguistic development
- The unique cultural influences children respond to from birth include:

1) Customs
2) Beliefs around food
3) Artistic expression
4) Language
5) Religion

2

Culture consists of the historically accumulated knowledge, tools and attitudes that pervade the child's ecology, including the cultural "practices" of nuclear family members and other kin.

Learning is understood as a relatively permanent change in behavior and understanding brought about by the child's experience.

Development entails qualitative changes in the functional organization of children's brain, body and behavior and in accompanying changes in the relationship between children and their socio-culturally organized experiences.

3

Early Formation of Racial Attitudes and Preferences

- Children usually recognize their racial ethnic background by about 3 or 4 years of age.
- Until about age 7 or 8 they show increased competency in perceiving their similarity to their own group.
- Children can accurately categorize different groups based on perceptual cues such as language and race and they can label groups consistent with adult labels.
- They understand that race and ethnicity don't change.

- The expressed racial/ethnic attitudes and preferences of White children between ages 4 and 7 shows they prefer to be with same group ethnic composition.
- Also – some hold negative attitudes toward other race and ethnic groups.

4

Parental Influence

Children rely on their parents for approval, comfort and security.

Parents have a powerful influence on their child's attitude development.

Parental behaviors that facilitate the development of negative racial, ethnic attitudes are:

- Not discussing racial issues at home.
- Not having a culturally diverse group of friends visit the house.
- Not confronting prejudicial remarks in the company of the child.
- Not pointing out the positive aspects and strengths of diverse cultures.
- Allowing children to remain in segregated environments.

5

- Children construct their views of self by participating in interactions that caregivers structure according to cultural values about the nature of human existence.
- In Western cultures, striving toward *independence* and individuality and asserting oneself are seen as important accomplishments.

Westerners perceive children who are outgoing, eager to explore new situations as:

- Demonstrating competence
- Having a positive self- concept

6

Children from cultures emphasizing interdependence tend to act less aggressively and more prosocially than children from nations where independence and competitiveness is valued (West/European/American)

Compared to European-American mothers:

- Chinese mothers believe that their child should act prosocially by conforming to group norms; fitting in
- Chinese mothers emphasize self-control as a childrearing practice.

7

- Early socialization of responsibility is associated with the development of prosocial-cooperative behavior.
- Cultures that value competitiveness and the pursuit of personal goals seem to allow for more coercive and aggressive behavior than cultures that emphasize group harmony.
- Studies show that North American children tended to exhibit higher levels of aggressive and externalizing behavior than their counterparts in some Asian countries such as China, Korea, Japan and Thailand.

8

Independent; Individualistic; Western Cultures
Interdependent, Collectivistic; Eastern; Central and South American Cultures.

- Western cultures are often described as valuing assertiveness, expressiveness and competitiveness.
- Eastern cultures are often described as valuing group harmony and cooperation.
- More recently, there has been agreement that most countries are a mix of both of these constructs, with some being relatively more individualistic and others relatively more collectivistic.

9

Temperament

Temperament is the biological basis of personality.

Research on the topic of temperamentally-based, reticent and inhibited behavior has reported differences in prevalence of this construct.

East Asians show a higher prevalence of inhibited behavior than Western Europeans, Americans

Inhibited behavior is viewed as reflecting compliance, obedience, being well-mannered, and thus, social maturity and accomplishment

Western cultures, which value independence and assertiveness, socially-inhibited and reticent behavior is viewed as reflecting shyness, fearfulness and social incompetence;

10

Differences in temperament also exist between cultures

Preschool children from Korea and China tend be more anxious, inhibited and withdrawn, and less sociable than their Western-European counterparts.

In Western cultures a child's inhibited conduct is associated with a risk of troubled peer relationships and internalizing problems (e.g., loneliness and depression

However, this is much less common in inhibited children from Eastern cultures.

In East-Asian cultures where group harmony is valued, an inhibited child is viewed as socially-competent, obedient and polite.

In contrast, an inhibited child in Western cultures is perceived as apprehensive and lacking in social skills

11

Prosocial Behavior

In general, prosocial behaviors (helping, sharing, caring, politeness) increases during the course of childhood.

It also varies across cultures.

Researchers find that prosocial behavior, as observed among peers and in parent-child interaction is more prevalent among young East Asian children than among Western children.

Researchers suggest that this difference results from the collectivist ideologies prevalent in East Asian cultures.

Chinese mothers of preschoolers are more likely than European American mothers:

- to believe that their preschool children should share and help other children for social conventional reasons; to fit in with the group and function well in Chinese society.

12

Cooperation/Competition

Competition can damage group harmony, cooperation is necessary in relationship maintenance.

Children from interdependent communities are more cooperative and less competitive than those from Westernized cultures.

However, competition and cooperation appear to co-exist regardless of culture.

In East Asian nations, children are more cooperative with friends and family, but more competitive in educational contexts.

Further, generational differences appear to exist within cultures.

For example, third generation Mexican Americans are more competitive than their second-generation counterparts.

13

Aggression

Physical, verbal and relational aggression have been identified as distinct entities in many cultures and countries.

Typically, physical aggression is viewed as unacceptable by parents and is associated with peer rejection in most countries.

Nevertheless, meta-analyses have demonstrated that cultures characterized by collectivistic and Confucian values generally show lower levels of aggression, regardless of type, towards peers than their Western counterparts.

14

Peer Relationships and Friendships

- Friendship is often referred to as a close, mutual and voluntary dyadic relationship.
- The voluntary nature of friendships means that children are able to initiate, maintain and relinquish friendships that meet their expectations and/or needs.
- In some cultures, children rarely engage in non-familial friendships.
- From an early age, most children form friendships with those who are similar to themselves in observable characteristics, such as age, sex, ethnicity, and behavioral proclivities

15

- In contrast, Eastern cultures place greater emphasis on maintaining harmonious, *interdependent* relationships.
- Interdependent views are also characteristic of many African, Latin American, and southern European cultures.
- In cultures influenced by Confucian and Taoist philosophies, self-restraint and control of emotional expressiveness is considered an indication of social maturity
- Asserting oneself may be seen as a sign of immaturity
- Children who are shy, reticent, and quiet are likely to be considered competent and well behaved by parents and teachers in the People's Republic of China

16

European-American children frequently provide long, elaborative, self-focused narratives emphasizing personal preferences and autonomy.

Their interaction style also tends to be reciprocal, taking turns in talking.

In contrast, Korean and Chinese children's accounts are usually brief, relation-oriented, and show a great concern with authority.

They often take a more passive role in the conversations.

In Chinese culture, where parents assume much responsibility and authority over children, parents interact with children in a more authoritative manner and demand obedience from their children.

Children growing up in such environments are more likely to comply with their parents' requests, even when they are reluctant to do so.

17

- Another finding that seems consistent across classes and ethnicities is that the more language a child is exposed to in the first years of life, the greater their vocabulary
- Language growth is especially helped by "extra talk" (i.e., talk that goes beyond simple directives and engages a child by highlighting and expanding on experiences) and by repetition
- Studies of young European American children have found a strong effect of socioeconomic class on the frequency of talk in mother-child dyads
- Parents from professional families tend to talk more to children than do working-class parents
- Working-class parents tend to talk more to children than do parents in poverty.
- These findings were strongly related the size of the children's vocabulary

18

To understand the environment's impact on a developing child, let's look at the three main ways children process the information around them as they grow.

Classical conditioning.

- Drawing associations between a stimulus and response.
- For example, children in religious families might associate bedtime with prayers.

Operant conditioning.

- Drawing associations between a reward and an action.
- For example, children might receive dessert after eating their vegetables.

Observational learning.

- Absorbing and copying what they see from others in real life or in the media.
- For example, a child might say, "Time to clean up" because a teacher says it in school.

19

- Children learn by observing and making associations about their surroundings.
- Exposure to positive influences can favorably impact a child's development, while exposure to toxic or stressful influences can negatively impact development.
- In other words, the social cues a young child takes in from others about cultural background can help or hamper development because developing children readily internalize what they see and hear.
- When a young child's cultural background differs from the prevailing culture — for example, the child's family might speak a different language at home, eat different foods, or observe different holidays — it can affect self-image.
- This is especially the case if peers or even teachers treat the child in a way that reveals bias or casts the child in the role of an outsider.

20

According to the National Association for the Education of Young Children (NAEYC), children are exposed to dominant social biases such as:

- Favoring people who are white
- Christian
- Heterosexual
- Able-bodied
- Thin
- Wealthy
- Fluent in English

Recognizing Cultural Influences on Child Development

- Culture influences development from the moment we're born.
- Culture can affect how children develop values, language, belief systems, and an understanding of themselves as individuals and as members of their society.
- Children can receive these cultural influences in different ways, such as through their parents, their environment, and the media.
- How society shows an understanding of diverse cultures can impact a child's development in many ways, such as how confident in themselves or how comfortable interacting with others they become as adults.

21

Collectivist vs. Individualistic Cultures and Parental Discipline

- Essentially, a collectivist culture values and rewards the prioritization of community needs over individual needs, as well as generous, kind, collaborative behavior.
- Collectivism is the norm in Asian, Central American, South American, and African cultures.
- On the opposite end of the spectrum, an individualistic culture values and rewards assertiveness and independent action, stressing the importance of the individual over the group.
- Individualism dominates in North American and Western European cultures.
- Individualist parents might discipline their children by taking something away that matters to them personally.
- On the other hand, parents from collectivist cultures might tell their children to think about how their behavior affects others.
- The study found that children raised in individualistic cultures often described themselves based on their unique attributes, such as "I am good at math."
- Meanwhile, children raised in collectivist cultures were more likely to describe themselves based on their relationships with others, such as "I am my mother's daughter."

22

Environmental Influences on Child Development

- Pollution from a nearby power plant, contaminated water, or lead in the home can cause lasting impacts on children's health.
- The health issues might not show up until later in life, causing difficulty in school, work, and socialization.
- A child exposed to polluted air, for example, might develop asthma as a teenager.
- Children of low-income communities are most likely to be at risk of exposure to environmental hazards.
- Low-income communities may have poor infrastructure, making them more vulnerable to the effects of natural disasters, such as contaminated water and damaged drainage systems.
- They may also be located closer to factories and highways, both of which contribute to high levels of pollution in the air, soil, and water.

23

Media Influences on Child Development

Media includes print, news, entertainment, television, video games

- The American Psychological Association (APA) says that children's exposure to violent media can result in aggressive behavior.
- Exposure to advertising for non-nutritious foods can increase rates of childhood obesity.
- A study from the Cognitive Impacts of Digital Media Workgroup found that children begin to learn from TV programs at around 2.5 years old.
- However, after they turn 6 years old, children begin to watch more entertainment programming which can influence their behavior negatively.
- Although video games can help children develop visual processing skills, they can also yield aggressive behavior.

24

Cultural Depictions in the Media that Promote Negative Racial Prejudice Include:

- Portraying minority groups in stereotypical roles
- Not portraying minorities in positive, leading roles; not having news anchors be minorities.
- Highlighting criminal activities found in some minority communities while neglecting to show positive aspects of minority communities.

25

HOW DOES CULTURE INFLUENCE EMOTION?

1

What is Culture?

Culture is the characteristics and knowledge of a particular group of people, encompassing language, religion, cuisine, social habits, music and arts.

- Culture is shared patterns of behaviors and interactions, cognitive constructs and understanding that are learned by socialization.
- It is the growth of a group identity fostered by social patterns unique to the group.
- "Culture encompasses religion, food, what we wear, how we wear it, our language, marriage, music, what we believe is right or wrong, how we sit at the table, how we greet visitors, how we behave with loved ones, and a million other things.

2

- Culture is not derived from biology or genetics.
- Culture refers to how a people interpret their world.
- Culture serves specific functions
- Culture also explains what are the important elicitors of behaviors.

- For example, some of us are fearful of snakes and some of us aren't

3

- Culture shapes our appraisal of emotions too.
- Appraisal gives meaning to things and they differ from culture to culture.
- For example – does threat always lead to fear?
- Does threat mean the same thing to all people?
- In the end – we ask to people appraise the same way?

4

How groups appraise depends on their values

For example – in America, if a good friend comes over to your house, you tell him/her to feel at home, grab anything you want from the refrigerator and make yourself at home.

In Japan – it would insult the guest if you told him/her to make themselves at home and help themselves to your refrigerator. It would be disrespectful to do this – the host needs to wait on their guest and so you say to your guest – what can I get for you.

Culture shapes how we show emotions.

There are what we call "Emotional Display Rules"

There are rules that dictate where and when it is appropriate to show emotions.

The Japanese suppress and inhibit emotions in front of others

Americans display emotions

5

EMOTIONAL DISPLAY RULES

- These are cognitive representations of what people believe they should o with their facial expressions when feeling specific emotions in social situations.
- They are used to protect one's feelings or other people's feelings.
- Example: masking your true feelings about your friend's terrible cooking.
- Cultural display rules are cultural norms learned early in life that govern the regulation of expressive behaviors depending on the social context.
- Display rules manage emotional expressions in many ways.

Summary

- Culture constrains how emotions are felt and expressed in a given cultural context.
- It shapes the ways people should feel in certain situations and the ways people should express their emotions.

6

Influence of Culture on Children's Development

- Early cultural exposure affects how children attend to themselves or to their relationship with others – forming their self image and identity.
- In Western European and North American countries, children tend to describe themselves using their unique characteristics – such as "I am smart" or "I am good at drawing".
- In Asian, African, Southern European and South American countries children describe themselves more often around their relationship with others and social roles.
- Examples of this include "I am my parents' child" or "I am a good student"

7

- Because children in different cultures differ in how they think about themselves and relate to others, they also memorize events differently.

- For example, when preschoolers were asked to describe a recent special personal experience,
- European-American children provided more detailed descriptions, recalled more specific events and stressed their preferences, feelings and opinions about it more than Chinese and Korean children.
- The Asian children instead focused more on the people they had met and how they related to them.

8

Cultural effects of parenting

Parents in different cultures also play an important role in molding children's behavior and thinking patterns

- Typically, parents are the ones who prepare the children to interact with wider society.
- Children's interaction with their parents often acts as the archetype of how to behave around others – learning a variety of socio-cultural rules, expectations and taboos.
- For example, young children typically develop a conversational style resembling their parents' style.
- European-American children frequently provide long, elaborative, self-focused narratives emphasizing personal preferences and autonomy.
- Their interaction style also tends to be reciprocal, taking turns in talking.
- In contrast, Korean and Chinese children's accounts are usually brief, relation-oriented, and show a great concern with authority.
- They often take a more passive role in the conversations

9

- In Japanese there is a word: Amae which means dependency.
- In America – we like autonomy.

- In the Czech language there is a word "Litost" which means torment; when you have insight to know you're not feeling well, are troubled.
- For example – the Tahitians see sadness as a physical condition.

Finally: there are culture specific absences; no words in some cultures.

1) Polish: they have no word for disgust
2) Tahiti: no word for guilt or sadness
3) Tibet: no word for emotion
4) Indonesia: no word for embarrassment

10

- In the West– the kinds of emotions we like tend to be high arousal ones, we like being happy, excited, energized and in positive moods.

- Hypercognized means a society has many words for an emotion: example is anger; it has multiple words such as rage, frustration, irritation.

- In the East – these people like relaxation, serenity, calmness, peace and they seek low arousal activities.
- Hypocognized means a society has fewer words for an emotion: example is feeling ill.

11

Common Cognitive Biases

1

- While people like to believe that they are rational and logical, the fact is that people are continually under the influence of cognitive biases.
- These biases distort thinking and influence our beliefs, sway the decisions and judgments that people make each and every day.

2

Confirmation Bias is the tendency to listen more often to information that confirms our existing beliefs.

We tend to favor information that reinforces the things we already think or believe.

It helps protect self-esteem by making people feel that their beliefs are accurate.

Examples include:

- Only paying attention to information that confirms your beliefs about issues such as gun control and global warming
- Only following people on social media who share your viewpoints
- Choosing news sources that present stories that support your views
- Refusing to listen to the opposing side.
- Not considering all of the facts in a logical and rational manner

3

The Halo Effect

The halo effect is the tendency for an initial impression of a person to influence what we think of them overall.

Also known as the "physical attractiveness stereotype" or the "what is beautiful is 'good' principle

For example:

- Thinking people who are good-looking are also smarter, kinder, and funnier than less attractive people
- Believing that products marketed by attractive people are also more valuable
- Thinking that a political candidate who is confident must also be intelligent and competent

4

The Self-Serving Bias

The self-serving bias is a tendency for people tend to give themselves credit for successes but lay the blame for failures on outside causes.

When you do well on a project, you probably assume that it's because you worked hard.

But when things turn out badly, you are more likely to blame it on circumstances or bad luck.

Some examples of this:

- Attributing good grades to being smart or studying hard
- Believing your athletic performance is due to practice and hard work
- Blaming your professor for performing badly on a test

5

The Availability Heuristic

The availability heuristic is the tendency to estimate the probability of something happening based on how many examples readily come to mind.

Some examples of this:

- After seeing several news reports of car thefts in your neighborhood, you might start to believe that such crimes are more common than they are.
- You might believe that plane crashes are more common than they really are because you can easily think of several examples.
- It is essentially a mental shortcut designed to save us time when we are trying to determine risk.
- The problem with relying on this way of thinking is that it often leads to poor estimates and bad decisions.
- Smokers who have never known someone to die of a smoking-related illness, for example, might underestimate the health risks of smoking.

6

The Optimism Bias

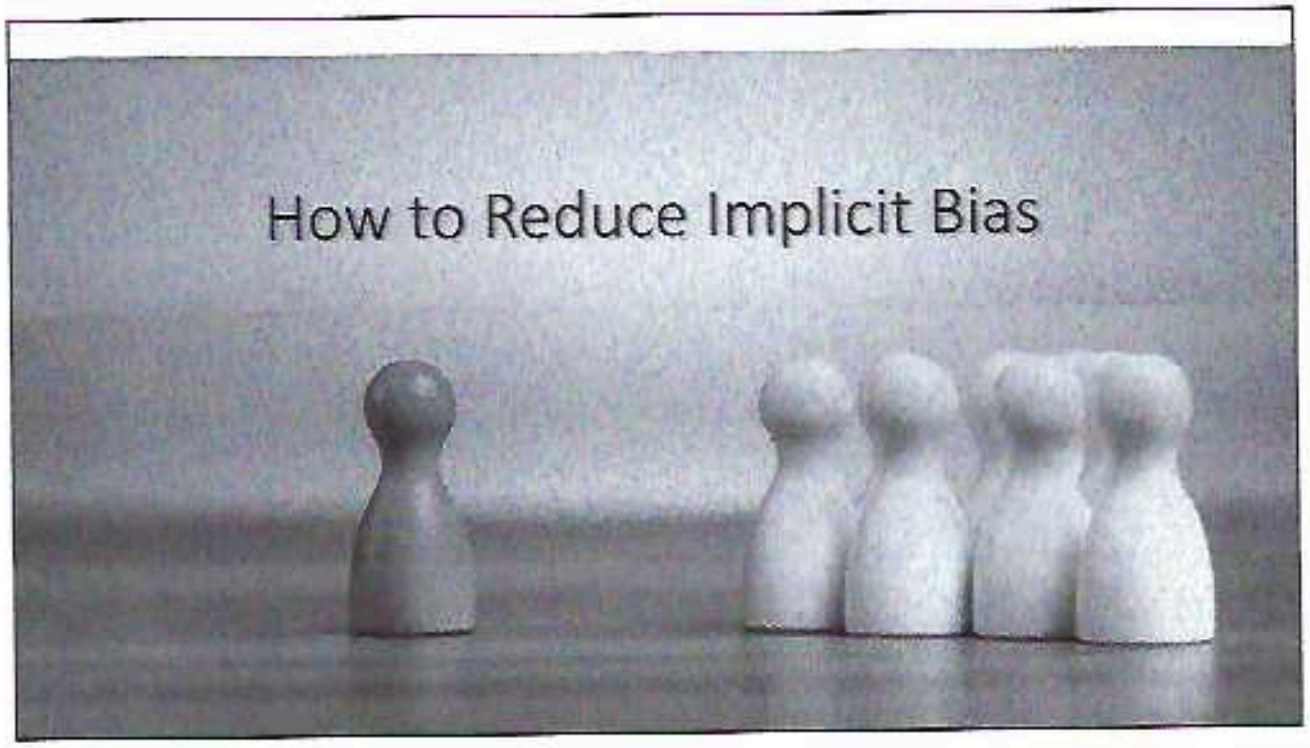
The optimism bias is a tendency to overestimate the likelihood that good things will happen to us while underestimating the probability that negative events will impact our lives.

Essentially, we tend to be too optimistic for our own good.

For example, we may assume that negative events won't affect us such as:

- Divorce
- Job loss
- Illness
- Death

7



1

Implicit biases impact behavior, but there are things that you can do to reduce your own bias

- **Focus on seeing people as individuals.**

  Rather than focusing on stereotypes to define people, spend time considering them on a more personal, individual level.

- **Work on consciously changing your stereotypes.**

  If you do recognize that your response to a person might be rooted in biases or stereotypes, make an effort to consciously adjust your response.

- **Take time to pause and reflect.**

  In order to reduce reflexive reactions, take time to reflect on potential biases and replace them with positive examples of the stereotyped group.

2

- **Adjust your perspective.**

  Try seeing things from another person's point of view.
  How would you respond if you were in the same position?
  What factors might contribute to how a person acts in a particular setting or situation?

- **Increase your exposure.**

  Spend more time with people of different racial and cultural backgrounds.
  Learn about their culture by attending community events or exhibits.

- **Practice mindfulness.**

  Try meditation, yoga, or focused breathing to increase mindfulness and become more aware of your thoughts and actions.

3

CULTURAL COMPETENCE SELF-ASSESSMENT CHECKLIST

This self-assessment tool is designed to help you explore your individual cultural competence. Its purpose is to help you consider your own skills, knowledge, and awareness in your interactions with others, and recognize what you can do to become more effective working and living in diverse environments.

The term "culture" includes not only race, ethnicity, and ancestry, but also the culture (e.g. beliefs, common experiences and ways of being in the world) shared by people with characteristics in common, including, but not limited to: people who are Lesbian, Bisexual, Gay and Transgender (LGBT), people with disabilities, members of faith and spiritual communities, and people within various socio-economic classes. For this tool, the focus is primarily on race and ethnicity.

Read each entry in the **Awareness**, **Knowledge**, and **Skills** sections. Place a check mark in the appropriate column which follows. At the end of each section add up the number of times you have checked that column. Multiply the number of times you have checked "Never" by 1, "Sometimes/Occasionally" by 2, "Fairly Often/Pretty Well" by 3 and "Always/Very Well" by 4. The more points you have, the more culturally competent you are becoming.

This is simply a tool. This is not a test. The rating scale is intended to help you identify areas of strength and opportunities for ongoing personal and professional development.

Awareness

		Never	Sometimes/ Occasionally	Fairly Often/ Pretty Well	Always/ Very Well
Value diversity	I view human difference as positive and a cause for celebration.				
Know myself	I have a clear sense of my own ethnic, cultural, and racial identity and how that is viewed by others with whom I differ.				
Share my culture	I am aware that in order to learn more about others I need to understand and be prepared to share my own culture.				
Be aware of areas of discomfort	I am aware of my discomfort when I encounter differences in race, religion, sexual orientation, language, and/or ethnicity.				
Check my assumptions	I am aware of the assumptions that I hold about people of cultures different from my own.				
Challenge my stereotypes	I am aware of the stereotypes I hold as they arise and have developed personal strategies for reducing the harm they cause.				
Reflect on how my culture informs my judgement	I am aware of how my cultural perspective influences my judgement about what I deem to be 'appropriate', 'normal', or 'superior' behaviors, values, and communication styles.				
Accept ambiguity	I accept that in cross-cultural situations there can be uncertainty and that I might feel uncomfortable as a result. I accept that discomfort is part of my growth process.				
Be curious	I intentionally make opportunities to put myself in places where I can learn about difference and establish diverse connections.				
Be aware of my privilege	If I am a white person working with members of BIPOC communities, I recognize that I have inherently benefited from racial privilege, and may not be seen as safe, 'unbiased,' or as an ally.				
Be aware of social justice issues	I'm aware of the impact of social context on the lives of culturally diverse populations, and how power, privilege, and social oppression influence their lives.				
		1 pt x	2 pt x	3 pt x	4 pt x

Adapted with permission from the Central Vancouver Island Multicultural Society

Knowledge

		Never	Sometimes/ Occasionally	Fairly Often/ Pretty Well	Always/ Very Well
Gain from my mistakes	I make mistakes and choose to learn from them.				
Assess the limits of my knowledge	I recognize that my knowledge of certain cultural groups is limited. I make an ongoing commitment to learn more through the lens of cultural groups that differ from my own.				
Ask questions	I listen fully to answers and make the time to advance my knowledge from a variety of existing culturally diverse resources before asking additional questions. I do this so that I don't unduly burden members of marginalized communities with addressing gaps in my cultural knowledge.				
Acknowledge the importance of difference	I know that differences in race, culture, ethnicity etc. are important and valued parts of an individual's identity—I do not hide behind the claim of "color blindness."				
Know the historical and current experiences of those I label as 'others'	I am knowledgeable about historical incidents and current day practices that demonstrate racism and exclusion towards those I label as 'others.'				
Understand the influence culture can have	I recognize that cultures change over time and can vary from person to person, as does attachment to culture.				
Commit to life-long learning	I recognize that achieving cultural competence and cultural humility involves a commitment to learning over a lifetime. I consistently demonstrate my commitment to this process.				
Understand the impact of racism, sexism, homophobia, and other prejudices	I recognize that stereotypical attitudes and discriminatory actions can dehumanize, even encourage violence against individuals because of their membership in groups that are different from mine.				
Know my own family history	I know my family's story of immigration and assimilation.				
Know my limitations	I continue to develop my capacity for assessing areas where there are gaps in my knowledge.				

continued on next page

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Knowledge continued

		Never	Sometimes/ Occasionally	Fairly Often/ Pretty Well	Always/ Very Well
Be aware of multiple social identities	I recognize that people have intersecting multiple identities drawn from race, gender identity, sexual orientation, religion, ethnicity, etc., and the potential influence of each of these identities varies from person to person.				
Acknowledge inter-cultural and intracultural differences	I acknowledge both inter-cultural and intracultural differences.				
Understand point of reference to assess appropriate behavior	I'm aware that everyone has a "culture" and my own "culture" is not to be regarded as the singular or best point of reference to assess which behaviors are appropriate or inappropriate.				
		1 pt x	2 pt x	3 pt x	4 pt x

Skills

		Never	Sometimes/ Occasionally	Fairly Often/ Pretty Well	Always/ Very Well
Adapt to different situations	I develop ways to interact respectfully and effectively with individuals and groups that may differ from me.				
Challenge discriminatory and/or racist behavior	I effectively and consistently intervene when I observe others behaving in a racist and/or discriminatory manner.				
Communicate across cultures	I adapt my communication style to effectively interact with people who communicate in ways that are different from my own.				
Seek out situations to expand my skills	I consistently seek out people who challenge me to increase my cross-cultural skills.				
Become engaged	I am actively involved in initiatives, small or big, that promote interaction and understanding among members of diverse groups.				
Act respectfully in cross-cultural situations	I consistently act in ways that demonstrate respect for the culture and beliefs of others.				
Practice cultural protocols	I learn about and put into practice the specific cultural protocols and practices that make me more effective in my work with diverse individuals and groups.				
Act as an ally	My colleagues who are Black, Asian, Latinx, and Indigenous consider me an ally and know that I will support them in culturally appropriate ways.				
Be flexible	I work hard to understand the perspectives of others and consult with diverse colleagues and diverse resources about culturally respectful and appropriate courses of action.				
Be adaptive	I know and use a variety of relationship building skills to create connections with people from whom I differ.				
Recognize my own cultural biases	I recognize my own cultural biases in a given situation and I'm aware not to act out based on my biases.				
Be aware of within-group differences	I'm aware of within-group differences and I do not generalize a specific behavior presented by an individual to the entire cultural community.				
		1 pt x	2 pt x	3 pt x	4 pt x

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RELIGIOUS/FAITH HEALING FOR MENTAL ILLNESS IN AFRICA, INDIA AND ASIA

1

RELIGIOUS HEALING

Healing is a central component of all religious systems and aims to restore health and wholeness; alleviate suffering.

- It can take many forms:
  - Miraculous supernatural interventions
  - Manipulating metaphysical energies to reorder human relationships
  - Religious healing can be effective at a psychological level but not provide a physical cure.

PRAYER

- It is an essential feature of most religions. (Western monotheism)
- It provides a source of meaning, purpose and coping and facilitates social bonding.
- It can be an effective coping strategy for stressful life events.

2

RITUAL

- Ritual is a central component of religion.
- A religious ritual is any repetitive and patterned behavior that is prescribed by or tied to a religious institution, belief, or custom, often with the intention of communicating with a deity or supernatural power.
- Rituals are an important aspect of religion because they allow believers to express and reaffirm their belief systems.
- One of the primary purposes of rituals is communication.
- Rituals communicate or are intended to communicate to self, others, or deities
- It confirms faith and invokes help from a deity and facilitates control of life.
- It can reduce anxiety and uncertainty in life
- It can provide meaning in life.
- It binds people and enhances social support.
- Confession is considered a ritual and it provides catharsis.

3

RELIGIOUS HEALING IN NON-WESTERN CONTEXTS

Africa

- African traditional healing emphasizes ancestral spirits.
- In the 19th century, many Africans became Christians through force rather than choice.
- Studies show that about 50% of the population of Africa with mental health problems consult traditional healers before accessing medical doctors.
- Herbalists use herbs and witchdoctors use spiritual techniques to expel mental illness.
- Faith healers use prayer, singing, counseling to cast out demons.
- Healers will touch the patient's forehead and read them scripture.
- Treatment modalities also include prayer, oils and holy water and counseling.
- Evil spirits are believed to cause mental illness.
- Diviners have access to supernatural powers through their ancestors.

4

India

Two thirds of people suffering from mental illness and their families maintain strong beliefs in the supernatural causes of mental illness and consult a traditional healer before accessing a medical/psychiatric practitioner.

These treatment options include:

- Ayurveda
- Folk Healers
- Healers in Temples
- Allopathic Healers

Patients are often accompanied by their families and reside with the patient up to a few days.

5

INDIA: FOLK & RELIGIOUS SECTOR

- The folk and religious sector are considered the primeval health care service providers in India
- In both sectors the chief cause of mental illness is breach of taboo (misdeed), personal sin, evil intent, angry deities, soul loss intrusion of elements, sorcery.
- A percentage believe that if one kills a cow during his/her life, he/she would suffer from mental illness in the present life.
- About 35% of Indians believe vaginal or semen secretion is one of the major causes of mental illness.

- Healing Practices
- The healing process is based on religious prayers, ritual activities.
- Ritual prayer includes fasting or eating raw fruits and performing prayer for regular periods of time.
- The priest performs the healing practices

6

INDIA: FOLK SECTOR

- The folk practitioners are labeled folk doctors, witch doctors, anti-witches or shamans.
- Typically they belong to poor, lower middle class families with no professional degrees.
- Healing practices include a mix of modern and traditional medicines with some religious prayers to cure the illness.
- The process of healing differs from patient to patient depending on symptoms.
- The hands, head, eyes, hair are examined and some numerical calculations are done.
- Chanting spells, poking the patient with pins, beating, flogging, slapping, tying with ropes and chains, scalding or blistering with a red, hot iron is done.

7

ASIA

- According to Mental Health America, Asian Americans are the least likely racial group in the United States to seek mental health
- The Asian American population is the fastest-growing ethnic or racial grouping in the U.S., increasing 72% between 2000-2015.
- In 2019, over 19 million people living in the United States identify as Asian American or Pacific Islander, representing 6% of the total U.S. population.
- Of these, roughly 15% report having a mental illness in the past year, meaning more than 2.9 million Asian Americans experienced mental illness in 2019.
- Findings from the National Latino and Asian American Study also found that 17.3% of Asian Americans will be diagnosed with a psychiatric condition at some point in their lifetime.

8

ASIA: STIGMA ASSOCIATED WITH MENTAL ILLNESS

- The APA claim stigma may play an important role in someone's likelihood to access care willingly.
- Fear of disability
- Studies found stigmas that associate mental illness with disability are the largest barrier to Asian Americans accessing mental healthcare.
- Cultural norms and values
- Shaming related to mental health is a cultural norm in some Asian American communities.
- Many Asian Americans also have strong family obligations that center around traditional and cultural values. Ancient Asian philosophical traditions strongly identify someone's self-value with their ability to care for their family and community.
- These notions encourage the idea that people with mental illness, who may not live up to these stereotypes, obligations, and values, are failures, valueless, or have no identity or purpose.
- These negative ideas can also discourage people from seeking treatment to avoid shaming themselves, their family, or their community.
- Getting outside help may also conflict with the Asian American cultural value of interdependence, which stresses that family or community can meet all a person's needs.
- This value perpetuates the idea that people should not seek professional help when relying on their family or community.

9

ASIA: THE MODEL MINORITY MYTH

- The model minority myth enforces the idea that all Asian Americans are fully-integrated, intelligent, industrious, and have overcome racial bias.
- This places pressure on those within this group to meet these standards or expectations.
- Furthermore, it encourages people to hide their historical influences and deny the fact that their life includes frustration, let-downs, setbacks, failures, pain, and loss that everyone experiences.
- Media portrayals often further encourage this stereotype by presenting one-dimensional, uncomplicated, and "universal" Asian American characters

Taboos

- Talking about mental health is taboo in many Asian cultures, perpetuating the idea that mental illness is shameful and that people should keep these issues private.

10

ASIA: LACK OF MENTAL HEALTH EDUCATION

- A lack of mental health awareness, coupled with negative stereotypes, may cause Asian Americans to overlook, reject, deny, or ignore mental health symptoms.
- They may also be more likely to assume mental illness is related to poor parenting or a genetic flaw passed down from parents.
- This can discourage people with mental illness, or their families, from seeking outside help to avoid being labeled as defective or damaged.

Religious or spiritual beliefs

- Several prevalent religions in Asian countries promote the idea that mental illness:
  - is a sin or divine punishment
  - represents disrupted energy flow or an internal imbalance
  - stems from a lack of faith
  - can be cured with enough faith, prayer, or good behavior
- Mental illness caused by a lack of harmony of emotions or by evil spirits
- Elderly Asian Americans believe the Buddhist principle that problems in this life are due to transgressions from a past life.

11

MENTAL ILLNESS AND STIGMA: ASIA, INDIA, ISLAMIC COUNTRIES

1

HOW MENTALLY ILL UNWITTINGLY EVOKE NEGATIVE RESPONSES IN SOCIETIES AND CULTURES

In Asia -- funding and recruitment of mental health professionals to psychiatry/mental health is largely determined by the attitudes, receptivity and awareness of those in power such as politicians and health care officials in decision making positions.

Factors in The Social Context That Contribute to Forming Community

Perceptions include:

- Availability and access to psychiatric services
- Availability of partial/day hospitals or programs at community mental health clinics
- Crisis stabilization units in inpatient psychiatric hospitals

2

RESPONSE OF CULTURE TO MENTAL ILLNESS AND STIGMA

Perceptions of mental illness are largely influenced by these factors in the culture:

- Etiology of the mental illness
- Experience of symptoms
- Recognition and labeling
- Treatments that are available
- Course of the illness

3

HORACIO FABREGA IDENTIFIES COMMON THEMES ON PSYCHIATRIC STIGMA IN SOCIETIES

- All illnesses are handled in an integrated psychosomatic way.
- Mental disorders are not separated from physical disorders
- In western cultures psychiatric disorders contain symptoms originating from the psyche/mind
- There is a tendency to rely on the medical model: such as insanity such as psychosis and severe behavioral abnormalities.
- There are more supernatural, religious, moralistic and magical approaches to mental illness.
- Conditions likely to have stigma attached are chronic, irreversible and relapsing.
- These are judged to be resulting from sorcery and spiritual punishment or hereditary; or resulting from moral transgressions.
- In Asian cultures, there is no distinction between mind and body.

4

SOMATIZATION IN CHINESE CULTURE

- Denial and suppression of affect
- Lack of vocabulary to express emotion
- Avoidance of social stigma
- Lack of mind-body differentiation

Familial Orientation

- Stigma of mental illness affects the entire unit/family and demands a collective response
- Stigma may be more severe because it is attached to the whole family
- The family shares the problem and attempts to solve it using their own resources
- Treatment may be delayed
- Some families in developing countries have lower levels of expressed emotion.

5

COPING STRATEGIES USED BY THE CHINESE

- Denial used to relieve the family of stigma
- Self-Control
- Passive response and Enduring One's Problems
- Containing the Problem to the Home
- Using Different Forms of Healing
- Herbs, special diets and traditional medicines
- There is strong resistance and delay in seeking psychiatric treatment
- Minor mental illnesses are treated by physicians
- The prediagnosis stage is often protracted and there is protection and use of intrafamilial resources
- The post labeling stage leads to despair and loss of tolerance, scapegoating and rejection.

6

ATTITUDES TOWARD MENTAL ILLNESS IN CHINESE CULTURE

- Based on Tao Chinese medicine focuses on restoration of balance according to theories of ying-yang
- Excess emotions are considered unhealthy
- Confucianism values: avoidance of emotions to preserve social harmony
- Psychological problems are expressed in a somatic organ based language
- The Chinese are not preoccupied with insanity and they didn't construct large psychiatric hospitals
- Historically the mentally ill received relatively humane treatment
- Also – evidence suggests that treatment of the mentally ill ranged from pity and compassion to harsh confinement.

7

CHINESE VIEWS ON CAUSES OF MENTAL ILLNESS

- It may be regarded as moral transgressions toward ancestors or social norms whereby the family is also held responsible.
- It can also be hereditary, ancestral inheritance of misconduct so that the sufferer and sometimes the siblings are excluded from marriage.
- It may include cosmological forces, wraths of G-ds, possession of spirits, demons and foxes, hormones, diet, brain dysfunction or political ideology.
- The family experiences intense shame and guilt too.
- Mental illness tarnishes family honor, name and ancestors
- Mental illness is largely viewed as biological by Chinese psychiatrists or are not interested in psychosocial or family dynamics.
- Training in psychiatry is lacking and doctors and nurses are very reluctant to work in mental health settings due to its low status, social stigma and the lack of rewards caring for the chronic, mentally ill.

8

JAPANESE CULTURE

- The attitudes are similar to the Chinese
- Psychological distress is frequently expressed in somatic terms.
- It is linked to psychological weakness such as lacking will power to exercise self-control
- Social discrimination is suffered by the mentally ill individual, marriage suffers.
- There is a cultural need for group approval associated with the shame culture leading to the family's wish to dissociate itself from the family member with the illness.
- The patient is discouraged from returning to society
- Self-victimization on the part of the mentally ill individuals as well as economic factors contribute to further isolation.
- There is use of mental hospitals in Japan and some are optimistic about recovery.

9

SOUTH-EAST ASIAN CULTURES

- Mental illness is viewed as madness and is considered untreatable among the Vietnamese
- Fear of one's mental problems being known to others and the concealment of distress reflect strong the strong stigma attached to patients and their families.
- Denial makes them reluctant to accept psychiatric treatment even if it is beneficial.
- They perceive seeking treatment as lack of endurance, personality strength and dignity.
- Traditional beliefs leads families to seek treatment from Buddhist priests, indigenous leaders with doctors and ritual practices.
- Among the rural Lao – cause is attributed to spirit, magic, breaking a taboo, thinking too much and bad blood.
- Folk concepts such as lost mind and brain illness are used.
- This means the sufferer is responsible and he/she will suffer rejection.
- In Malaysia, mental illness is associated with supernatural causes and punishments for past transgressions.
- Traditional and religious healers are sought first.
- There is prejudice against the practice of psychiatry.

10

INDIAN CULTURE

Severe mental illness or Unmada in Indian culture is largely influenced by Ayurvedic or Indian classical medicine traditions

Folk traditions emphasize supernatural causes

Ayurvedic describes mental illness in terms of humoral imbalance.

Other indigenous concepts include astrology, karma, intense stressors such as physical illness.

Typically psychiatric patients have contact with other healers before seeing a mental health expert.

Ayurvedic medicine does not regard psychiatric illness in any special way that is stigmatizing.

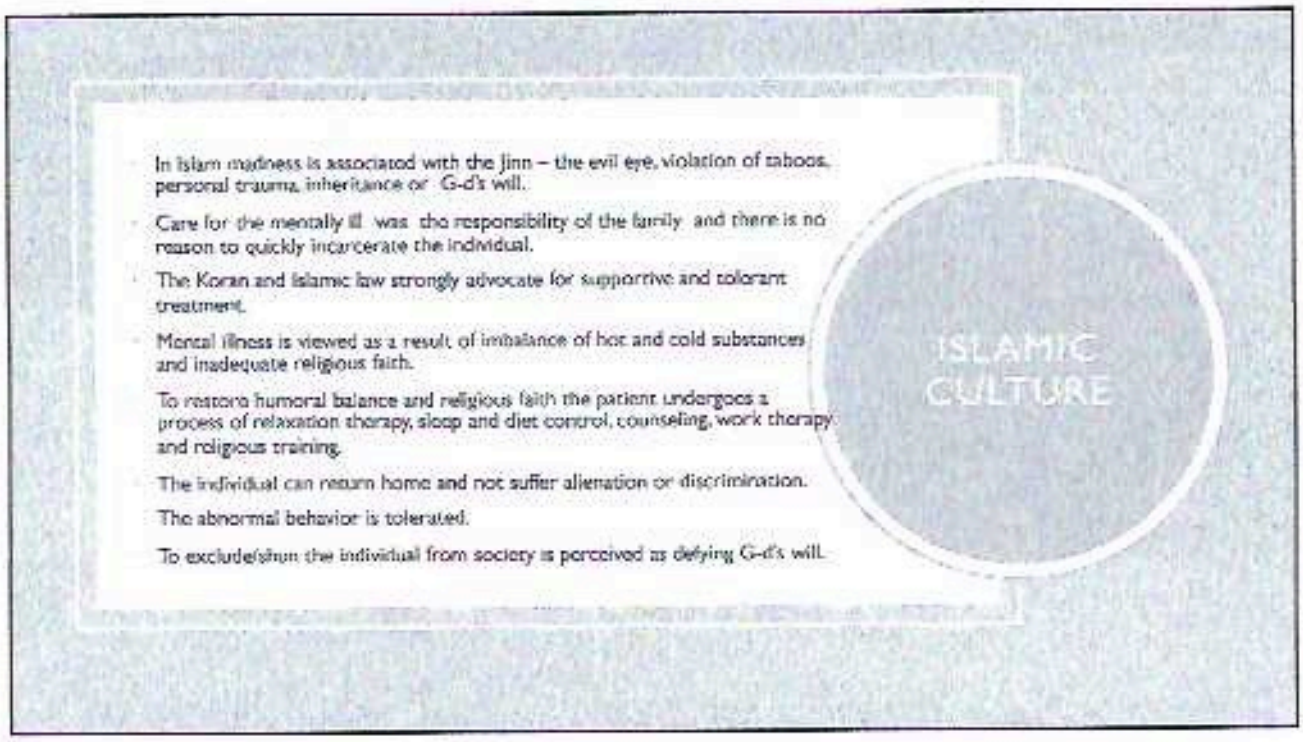
Ayurvedic treat the mentally ill in humane and sympathetic ways.

Historically – because of the rigid caste system traditional moral and ethical codes shows some evidence of social discrimination towards the mentally ill.

11

- In India there is poor recruitment to the profession of psychiatry.
- Attitudes of medical students surround low salary in the practice of psychiatry.
- It is perceived as being of low status and career opportunities.
- They are concerned how they will be perceived by their medical colleagues.
- Undergraduate training is unsatisfactory
- Overall – there exists a negative professional attitude toward psychiatry.

12



- In Islam madness is associated with the Jinn – the evil eye, violation of taboos, personal trauma, inheritance or G-d's will.
- Care for the mentally ill was the responsibility of the family and there is no reason to quickly incarcerate the individual.
- The Koran and Islamic law strongly advocate for supportive and tolerant treatment.
- Mental illness is viewed as a result of imbalance of hot and cold substances and inadequate religious faith.
- To restore humoral balance and religious faith the patient undergoes a process of relaxation therapy, sleep and diet control, counseling, work therapy and religious training.
- The individual can return home and not suffer alienation or discrimination.
- The abnormal behavior is tolerated.
- To exclude/shun the individual from society is perceived as defying G-d's will.

13