EVOLUTION OF A CROSS-CULTURAL COUNSELING CLINIC

I. INTRODUCTION
   A. Sensitivity to cultural factors in treatment of patients in family medicine
   B. "Family" has many meanings, structures, relationships
   C. Even "medicine" implies different understandings, and patterns of authority

II. DEFINITIONS
   A. Ethnicity - "Those who conceive of themselves as alike by virtue of their common ancestry, real or fictitious, and who are so regarded by others" (Shibutani & Kwan, 1965)
   B. Culture - "Highly variable systems of meanings which are learned and shared by a people or an identifiable segment of a population" (Rohner, 1984)

III. CROSS-CULTURAL COUNSELING: SOME BASIC PRINCIPLES
   A. Autoplastic - alloplastic dilemma
      1. Western modalities: strong autoplastic bias
      2. Non-Western helpers more alloplastic
      3. Autoplastic - loss of cultural identity
      4. Alloplastic - tradition-oriented patients become prisoners of their own culture
   B. Two divergent trends in psychotherapy
      1. Culture specific model
      2. Universal perspective
      3. Resolution: Therapy with ethnic minorities must involve a multisystems approach

IV. TRADITIONALISM VS. MODERNISM
   A. Another way to define role of culture is to consider an individual's endorsement of traditional and/or modern values
   B. Western values
   C. Third World values

V. BARRIERS TO EFFECTIVE CROSS-CULTURAL COUNSELING
   A. Bias in assessment, diagnosis, and treatment
      1. Bias in interpretation
      2. Bias in diagnostic instrument
      3. Bias of language
      4. Bias in diagnosis
   B. Potential for oppression exists in any helping modality
      1. Potential exploitation
      2. Paternalism
      3. Stigmatization

C. Matched or unmatched counseling?

VI. INTERPRETER TRAINING
- A. One 3 hour workshop
  1. Confidentiality
  2. Practice in simultaneous translation
  3. Sensitive nature of many issues discussed for pt., physician, and interpreter
- B. Basic Rules of Interpreting
  1. Personal nature of material discussed
  2. Accurate translation of both physician and patient
  3. Raising concerns promptly about any potentially problematic questions
  4. Providing commentary as an observer
  5. Being honest about own language skills

VII. RESIDENT TRAINING
- A. Family Genograms
- B. Cross-cultural medicine didactics
  1. Goals and objectives
  2. Introductory presentation on ethnosensitivity, counseling models
  3. Resident presentations

VIII. GOALS OF RESIDENT TRAINING
- A. Developmental model of ethnosensitivity
- B. Specific concerns in resident training
  1. Awareness of one's own culture
  2. Avoidance of stereotyping and assumptive bias
  3. Pseudo-explanatory models
  4. Acculturation
  5. How to use culture
  6. Evaluating cultural information
     - a. How true is cultural stereotype in general
     - b. How well does it translate in the particular
     - c. What are the actual implications for adjustment of professional practice style in light of this knowledge
  7. When cultures clash - everything is not relative
- C. Learning how to work with an interpreter
- D. Cross-cultural medical therapeutics
  1. Clarification of information
  2. Support/normalization
  3. Reassurance/reinforcement
  4. Interest in pt. as a person
- E. Brief counseling strategies
  1. Adaptation of techniques to increase familiarity

2. Cognitive reframing
3. Solution-focused
4. Social support
5. Search for meaning
6. Narrative therapy

F. Awareness and utilization of community resources

IX. EFFECTIVENESS OF CROSS-CULTURAL COUNSELING: Preliminary data

A. Results of patient satisfaction survey

B. Results of counseling clinic intervention

1. Reduction in urgent care and regular clinic visits
2. Primarily true for depression

TABLE 2:

Summary of Strategies Goals, and Content: Development Model of Ethnosensitivity

STAGE	FEAR	DENIAL	SUPERIORITY	MINIMIZATION	RELATIVISM	EMPATHY	INTEGRATION
PRIMARY APPROACH OR STRATEGY	COGNITIVE						
	AFFECTIVE						
				EXPERIMENTAL			
GOALS	Decrease or Eradicate Fear	Promote Recognition of Differences and Ethnicities	Promote Recognition of Similarities	Stress Bio-psychosocial Awareness Debunk "Common Sense"	Promote Cultural Education & Contextual Evaluation Foster Empathy	Facilitate Affective & Experimental Cultural Awareness & Pluralism	Foster Integrative Skills & Multiculturality
CONTENT	Directed Information Balint or Therapy Groups Psychotherapy	Cultural Awareness Activities Broaden Medical Interview	Demystification Inoculation Normalizing Experiences	Biopsychosocial Model Culture Specific Activities Enlightening Experiences	Experiental Learning Cultural Value Games Generalizable Frameworks	Getting out into the Field Intercultural Training & Communication	Experiental Learning & Refinement Medical Ethics

CROSS CULTURAL COUNSELING ASSUMPTIONS

1. Poor people must, of necessity, be more concerned with survival issues, such as food and shelter, than with emotional or psychological issues.

2. Vietnamese patients will not disclose their emotional states.

3. Latino patients generally have large, extended families that take care of most of their emotional and psychological needs.

4. Vietnamese male patients find it humiliating to discuss their problems with a white younger woman professional.

5. Most of the somatization seen in Vietnamese patients is attributable to their difficulties in acculturation.

6. Latino patients will often agree with the physician out of respect, even when they have reservations about her suggestions.

7. Vietnamese patients are comfortable with physicians who assume the role of partner in health care.

8. Latino patients are most concerned with a friendly relationship with their physician.

9. The concept of patient narrative is not as relevant to Latino or Vietnamese patients as it is to Caucasian patients.

10. Fatalism means that Latino patients are much less likely than Caucasian patients to take a proactive stance toward disease.

11. Losing face is an important therapeutic concept in the Vietnamese community, but not for Latino patients.

12. Silence in the Vietnamese patient is a sign that they are indirectly disagreeing with you.

CROSS-CULTURAL COUNSELING RESPONSES

1. A Maslovian hierarchy may be simplistic in working with indigent patients. It is a mistake to assume that a woman living out of her car is more concerned with finding a shelter than she is with discussing her estranged daughter.

2. Not necessarily. While it is true that depression, for example, tends to present with highly somatized expressions, some Vietnamese are quite articulate with emotional language.

3. Again, while traditionally this is true, Hispanic/Latino families in the United States are often fragmented, and individuals isolated. Thus, while many Latinos may be culturally more comfortable turning to informal support networks for assistance, these are not always readily available.

4. This is sometimes the case. However, balancing age and gender drawbacks is the authority of the professional, particularly the physician. In addition, it appears that at times the cultural difference may actually facilitate patient disclosure: While Vietnamese traditionally do not readily divulge personal/emotional problems outside the family unit, this cultural taboo becomes more flexible when dealing with professionals who are representative of a different (ie., American) culture.

5. While acculturation difficulties play a key role in the development of affective and health related symptoms, we must not minimize the long-lasting effects of the extreme traumas of war and emigration.

6. This is often true, and suggests we must be more diligent in probing our patient's true feelings about diagnoses and treatment plans.

7. Generally, Vietnamese patients are not familiar with the model of the therapeutic partnership. They expect physicians to be experts, and to give them specific advice and prescriptions. However, they also assume they will be listened to respectfully and treated in a dignified manner.

8. It is true that a "friendly," in the sense of cordial, interpersonal relationship is valued by many Latino patients. However, of equal importance is the existence of a feeling of respect between patient and physician.

9. False. Patients from both these cultural backgrounds are especially anxious to tell their story, and even more importantly, have it listened to.

10. This is a widespread misconception. Fatalism rarely means, for example, that parents are unwilling to seek treatment for an ill child because "it is in God's hands" or "it is God's will." Fatalismo implies a certain level of acceptance of illness event and outcome. However, failures to comply with treatment should not be explained by fatalism except as a last resort, and other causes, such as miscommunication, should be diligently explored.

11. False. Losing face, embarrassing or shaming the patient, carries important weight in both the Latino and Vietnamese communities.

12. Sometimes. However, silence is also a sign of respect. Again, this argues for the importance of clarification in communication.

FAMILY MEDICINE IN A MULTIETHNIC CONTEXT

LEARNING OBJECTIVES

The learner should be able to:

1. Describe a developmental model of ethnosensitivity and place oneself along its continuum.

2. Describe how world views and value dimensions may distinguish between ethnic groups.

3. Identify barriers to effective cross-cultural health care and approaches to developing a trusting, supportive doctor-patient relationship.

4. Demonstrate familiarity with and be able to implement Kleinman's questions for eliciting patient health beliefs.

5. Describe and demonstrate basic guidelines for provider-interpreter-patient interactions.

6. Demonstrate knowledge of the following cross-cultural issues for either Latino or Vietnamese patients:

   a. Within group diversity
   b. Prevalent stressors (emigration events; acculturation; racism)
   c. Values and cultural beliefs
   d. Role of family
   e. Theories of disease, illness, and folk remedies

7. List possible characteristics of ethnic patients and families in the health care system and strategies for successful medical intervention.

8. Demonstrate familiarity with specific cultural beliefs that may influence interaction of patients, families and physicians in health care situations.

MENU OF LEARNING EXERCISES

1. Prepare a brief annotated bibliography (10 references).

2. Videotape and present an encounter with a culturally different patient and/or family member(s).

3. Interview an "expert" (medical anthropologist, primary care physician with special cross-cultural background) regarding one of above learning objectives and prepare a two page summary of interview.

MENU OF LEARNING EXERCISES (CONTINUED)

4. Develop a brief role-play addressing one of the learning objectives above.

5. Prepare a three page summary of library research on one of the above objectives

6. Prepare a 2-3 page statement addressing one of the above learning objectives from the personal perspective of your own cultural background.

7. Complete a family genogram with an ethnically different patient to illustrate one of the learning objectives listed.

8. Complete your own family genogram to address the interaction of culture and health beliefs.

1. how many - culturally diverse settings
2. how many - non Hispanic white?
2 white women talk about culture

EVOLUTION OF A CROSS-CULTURAL COUNSELING CLINIC

I. INTRODUCTION — SLIDE

A. Emergence of sensitivity to cultural factors in treatment of patients in family medicine

B. Come to realize "family" has many meanings, structures, relationships

C. Similarly, even "medicine" implies different understandings, communications, and patterns of authority

D. These developmentss beneficial to pts., families and physicians

E. Also critical because of major demographic shifts

F. Increasing ethnic diversity among residents

G. Importance of systematically teaching skills

II. DEFINITIONS SLIDE

A. Ethnicity -

1. "Those who conceive of themselves as alike by virtue of their common ancestry, real or fictitious, and who are so regarded by others" (Shibutani & Kwan, 1965)

2. Group of individuals who share a unique cultural and social heritage passed from one generation to another

B. Culture -

1. "Those sets of shared world views and adaptive behaviors dervied from simultaneous membership in a variety of contexts" (Falicov, 1988)

2. "Highly variable systems of meanings which are learned and shared by a people or an identifiable segment of a population" (Rohner, 1984)

III. CROSS-CULTURAL COUNSELING: SOME BASIC PRINCIPLES — SLIDE

A. Autoplastic -alloplastic dilemma — Stages of Change

1. How much should patient be encouraged in traditional cultural behaviors, and how much should be encouraged to change?

2. Western modalities: strong autoplastic bias

a. Patients encouraged to abandon traditional beliefs, behavior in order to fit into dominant society

b. Non-Western helpers more alloplastic: only encourage new behavior if it is compatible with traditional ways of doing things

3. Dangers

a. Autoplastic -loss of cultural identity

b. Alloplastic - tradition-oriented patients become prisoners of their own culture

B. Two divergent trends in psychotherapy — Culture-specific vs. universalism

1. Culture specific model

a. In this model, values, beliefs, orientation of different groups are learned

b. Differences between these groups and majority culture stressed

c. May lead to stereotyping: "Multicultural cookbook

with a recipe"

d. Trainees must memorize each cultural variation

e. Acknowledging acculturation a major problem

2. Universal perspective

a. Eurocentric counseling approaches appropriate regardless of ethnic or cultural factors

b. No reason to modify therapy to fit different groups

c. Variant: identify human processes that are similar, regardless of ethnicity or cultural background

1. Characteristics "basic" to all people - grief

2. Becomes to vague and general to lead to productive intervention

3. Resolution:

a. Therapy with ethnic minorities must involve a multisystems approach

1. See pt. in context of family and culture

2. Recognize profound impact of other systems (medical, welfare, educational) in pt. life

b. Emphasis on understanding how pt. defines self in relation to culture

c. Incorporation of indigenous perspectives in treatment

III. TRADITITIONALISM VS. MODERNISM - HANDOUT

A. Another way to define role of culture is to consider an individual's endorsement of traditional and/or modern values

B. Western values: freedom of choice, uniqueness of individual, independence, autonomyu, nonconformity, competition, expression of feelings, fulfillment of individual needs

C. Third World values: group decision-making, family priority, conformity, compliance, cooperation, harmony, control of feelings, achievement of group needs

D. Assess your own values

IV. BARRIERS TO EFFECTIVE CROSS-CULTURAL COUNSELING - SLIDE

A. Bias in assessment, diagnosis, and treatment

1. Bias in interpretation: Symptoms may have culture-bound meaning (ie, hearing voices of recently deceased relatives not unusual among some Native Americans and Mexicans from inner regions of country); so essential to evaluate mental health significance of an observed or reported phenomenon

2. Bias in diagnostic instrument: Depending on sensitivity of instrument, wide variability in rates of mental illnesses such as OCD, dysthymia

3. Bias of language: Some language studies suggest more pathology evident when interview conducted in Spanish, some less

4. Bias in diagnosis: Documented tendency for schizophrenia, severity of major diagnoses to be overdiagnosed in low ses and minority patients

B. Potential for oprression exists in any helping modality

1. Different cultural groups often less powerful

a. Potential of exploitation

b. Potential to impose therapist beliefs

2. Paternalism - if we (members of the dominant culture) can understand people from other cultures a bit better, we can be more

successful in getting them to do what we know is best for them

3. Stigmatization - low ses and minority pts. often seen by therapists as nonparticipatory, uncooperative, uninsightful, untreatable

a. Reinforcement of negative stereotypes

b. Support of generalized demoralization due to poverty, discrimination

C. Matched or unmatched counseling?

1. Many studies suggest matching of language and culture between therapist and patient produces best therapy

2. Study 1981 by Ruiz documents that influx of Hispanic professionals will not accelerate as rapidly as Hispanics' need for culturally sensitive services

3. Some studies suggest well-trained, empathic helpers can establish effective relationships with people from other cultural, ethnic backgrounds

4. Our program not to train cross-cultural therapists

a. Most patients of different ethnic backgrounds tend to seek medical rather than psychological help for problems

b. Importance of training family practice physicians to apply brief therapeutic and counseling approaches in a culturally sensitive manner

V. HISTORY OF CLINIC - SLIDE

A. Patient population

~~1. 1991-2: 65% Latino; 25% Vietnamese~~ 20 40

2. 1994: 50% Latino; 40% Vietnamese

3. Number of total patient visits:

a. Gender 41% ♂ female 59%

b. Age 85% 15-

4. Number of counseling clinic visits

1. 1991-2: approximately 180 possible visits (9 residents x 2 visits x 10 months)

2. 1993-4: approximately 600 possible visits (10 3rd years x 4 visits x 10 months) (10 2nd years x 2 visits x 10 months)

Community Consultation
Nueva Esperanza
Vietnamese Community Mental Health
own frenetty

B. Description of residents SLIDE

A. 3rd years by ethnic background

B. 2nd years by ethnic background

C. 1st years by ethnic background

VI. Interpreters SLIDE

A. 199 students: pre-med and biology majors

B. ROP students

C. Community volunteers (older, more mature)

D. Interpreter training

1. One 3 hour workshop (materials from Pat)

a. Issues of confidentiality

b. Practice in simultaneous translation

c. Sensitive nature of many issues discussed for pt., physician, and interpreter

2. On-the-job training: Basic Rules of Interpreting

a. Personal nature of material discussed

b. Accurate translation of both physician and patient

c. Raising concerns promptly about any potentially problematic questions

d. Providing commentary as an observer

e. Being honest about own language skills

VII. RESIDENT TRAINING

A. Orientation: Family Genograms

B. One month of cross-cultural material

1. Goals and objectives

2. Introductory presentation on ethnosensitivity, counseling models

3. Resident presentations

VIII. GOALS OF RESIDENT TRAINING

A. Developmentmental model of ethnosensitivity

1. Awareness of own biases and attitudes in relation to other cultures

2. Continuum

a. Fear of general differencees, specific groups

b. Denial - cultural differences do not exist or unimportant; overgeneralization about how people behave

c. Superiority - see own culture as superior (reversal - glorification of other's culture)

d. Minimization - emphasis on universalism, basic human similarities

e. Relativism - ethnic and cultural differences acknowledged and respected; naivete about other cultures

f. Empathy - ability to shift frame of reference so as to experience events as patient might

g. Integration

3. Elaboration on above model

B. Specific concerns in resident training

1. Awareness of one's own culture

2. Avoidance of stereotyping and assumptive bias

3. Pseudo-explanatory models

4. Confounding of race, culture, and class

5. Culture of patient, culture of physician

6. Acculturation

7. How to use culture

a. Superficial knowledge may provide hints where to look for patients' strengths and weaknesses (resiliency in refugee culture)

b. Importance of sensitivity to nonresponsiveness on part of patient

c. Suggests misuse of particular piece of cultural information, wrong cultural leap

d. Be aware of dynamism of culture - culture is not static

e. Cultural differences do exist but are often subtle (matter of degree, emphasis, particular way construct is expressed)

f. Evaluating cultural information

1. How true is cultural stereotype in general

2. How well does it translate in the particular

3. What are the actual implications for adjustment

of professional ~~practice style~~ in light of this knowledge

8. When cultures clash - everything is not relative SLIDE

C. Learning how to work with an interpreter HANDOUT Monolingual

D. Cross-cultural ~~medical therapeutics (chk term depression material)~~ clinical management SLIDE

1. Can disappear in cross-cultural encounter
2. Clarification of information, i.e. medication schedule
3. Support/normalization
4. Reassurance
5. Interest in pt. as a person

E. Brief counseling strategies SLIDE

1. Adaptation of techniques to increase familiarity
   a. Prayer instead of relaxation
   b. Family stroll instead of exercise
2. Cognitive reframing:
   a. Survivor (of rape by coyote; of re-education camps)
   b. Helping self vs. how solutions may increase chances for harmony in family, help other family members, or enable patient to perform duty as family member (Asian)
   c. Strong character solves own problems vs. sign of strength to ask for help
3. Solution-focused: Behavioral activity (don't push for expression of emotion, but offer empathy, respect)
4. Social support
   a. informal (identifying and mobilizing networks)
   b. formal (social resources)
5. Search for meaning
   a. Diaries, letters for grandchildren
   b. Teaching Vietnamese to VN-American students
6. Narrative therapy - history of lives

F. Awareness and utilization of community resources

1. Nueva Esperanza and Vietnamese Community Center
2. Consultation with Latino and Vietnamese physician faculty regarding specific problem cases

VIDEO

IX. EFFECTIVENESS OF CROSS-CULTURAL COUNSELING: Preliminary data

A. Results of patient satisfaction survey SLIDE - demographics

B. Results of counseling clinic intervention SLIDE - results

1. Reduction in urgent care and regular clinic visits
2. Primarily true for depression

SLIDE pt. satis.

CROSS-CULTURAL COUNSELING

I. DEFINITIONS
   A. Ethnic group - group of individuals who share a unique cultural and social heritage passed from one generation to another
   B. Ethnicity plays important role in determining individual's diet, work habits, religious beliefs, philosophy of life, methods of coping with illness and death

II. AUTOPLASTIC-ALLOPASTIC DILEMMA
   A. How much should patient be encouraged in traditional cultural behaviors, and how much should be encouraged to change?
   B. Western helping modalities: strong autoplastic bias
      1. Patients encouraged to abandon traditional beliefs, behavior in order to fit into dominant society
      2. Non-Western helpers more alloplastic: only encourage new behavior if it is compatible with traditional ways of doing things
   C. Dangers
      1. Autoplastic - loss of cultural identity
      2. Alloplastic - tradition-oriented patients become prisoners of their own culture

III. HELPING MODALITIES
   A. All helping modalities attempt to change people
      1. Help them think diggerently (cognitions)
      2. Help them feel differently (affect)
      3. Help them act differently (behavior)
   B. All helping modalities assume individuals have potential to alter their life situations; or at least themselves in relation to these situations

IV. OPPRESSION AND LIBERATION IN THE THERAPEUTIC RELATIONSHIP
   A. Potential for oppression exists in any helping modality
      1. different, exotic cultural groups also less powerful
      2. Paternalism - if we (members of dominant culture) can understand people from other cultures a bit better, we can be more successful in getting them to do what we know is best for them
   B. Stigmatization of untreatability
   C. Liberation requires both reflection (self-understanding) and action
      1. Ridding clients of myths
      2. Watch out therapists don't become the/rapists when dealing with culturally different population
      3. Avoid exploitation ("If I disagree with you I won't impose my beliefs on you")
      4. Avoid reinforcing negative self-image, generalized feelings of demoralization engendered by poverty
   D. Realization that healers as well as patients are dwellers within culture
      1. Not only "us" learning about "them"

2. Us learning about us in the process of learning about them

V. BARRIERS TO CROSS-CULTURAL HELPING
   A. Such helping difficult because of differences in language, custom, culture
   B. Some studies suggest well-trained, empathic helpers can establish effective relationships with people from other cultural, ethnic backgrounds
   C. Western values: freedom of choice, uniqueness of individual, independence, autonomy, nonconformity, competition, expression of feelings, fulfillment of individual needs
      1. These translated into therapeutic approaches
      2. See Table 2
   D. Third World values: group decision-making, family priority, conformity, compliance, cooperation, marny, control of feelings, achievement of group needs
      1. Unity of psyche and soma
      2. Third world peoples likely to explain their emotional and physical illnesses in terms of imbalance between individual and physical, social, spiritual worlds
      3. Prevalence of humoral pathologies
         a. Basic functions of body regulated by four bodily fluids (blood, phlegm, black bile, yellow bile)
         b. Each of these characterized by combination of hot, cold
         c. Good health maintaining balance between hot and cold

VI. DEVELOPMENTAL MODEL OF ETHNOSENSITIVITY
   A. Fear
      1. of general differences
      2. of specific ethnic groups
   B. Denial
      1. behave as if cultural differences do not exist or are unimportant
      2. overgeneralization about how people behave
   C. Superiority
      1. recognize cultural differences, but see own culture as superior
      2. negative stereotyping/reversal (glorification of other's culture)
   D. Minimization
      1. cultural differences exist, but are unimportant compared to basic human similarities
      2. emphasis on universalism
   E. Relativism
      1. ethnic and cultural differences acknowledged and respected
      2. naivete about other cultures
   F. Empathy
      1. ability to shift frame of reference so as to experience events as patient might
      2. understanding of pluralism
   G. Integration
      1. can stand both inside and outside of culture

2. have both deep understanding and critical viewpoint

VII. SOME CONCEPTS REGARDING LATINO CULTURE
A. La Raza - unity of all Latinos by cultural, spiritual bonds
B. God controls all events: Latinos more present-oriented than future-oriented
C. Family loyalty - primacy of family
D. Respect - accorded on basis of age and gender
E. Machismo
1. Men stronger, more reliable, more intelligent than women
2. Weakness in male behavior looked down on
3. Females can be strong in their prescribed roles
F. Compadrazgo - special bond between child's parents, godparents
G. Helping modalities effective with Hispanics must allow for
1. Afecto (warmth and demonstrativeness)
2. Dignidad (dignity)
3. Fatalismo (fatalism)
4. Machismo (male superiority)
a. should not be equated with inability to express affect
b. expression of feeling by men and between men more open in Latino culture
c. more male-male touching
5. Respeto (respect for authority, family, tradition)

VIII. ASPECTS OF THERAPY WITH HISPANICS
A. Hispanics good candidates for behavioral, family, and networking therapies
1. Appreciate goal-orientation, straight-forward approach
2. Difficulties in self-disclosure
3. One does not reveal personal, family information
4. Individual goals often subordinate to group goals
5. Paradox, confrontation may be inappropriate because cause patient to lose face
6. Mental illness seen as stigmatizing, not possible in "good" families
7. Main symptoms (anxiety, depression) may be somatized
8. Importance of non-blaming approach
B. Specific aspects of therapy
1. Physical comfort zones closer for Hispanics
2. Eye contact
a. staring rude
b. forced eye contact interpreted as loss of respect
c. looking subordinate in eye seen as punitive, judgmental
3. Touch
a. more within-sex touching than Anglos
b. avoid placing arm on shoulder of Hispanic male patient
4. Directiveness/Concreteness
a. Not being proactive seen as lack of clear helping
b. Helpers should ask questions, then generate suggestions

c. This must be done without showing disrespect, encouraging submissiveness
d. Authority figures expected to set limits, offer advice, but patient must make up own mind
e. Patient wants guidance, structure, advice, without in-depth probing of family problems
f. Concrete rather than global solutions
g. Avoid prolonged conversation focusing on future goals or childhood experiences
h. Gender issues - receiving help from woman professional may be problematic

5. Use of names
a. Use of first names inappropriate
b. Formal address preferred
c. Call people by their right names, correct pronunciation

6. Language
a. Latino patients consistently rated as more pathological when interviewed by English speakers as opposed to Spanish speakers
b. Translators may lose nuances of feeling
c. Dynamics change from dyadic to triadic
d. Family members may censor, reinterpret
e. Second language more abstract, detached - less tendency for emotional expression

IX. SOUTH-EAST ASIAN PATIENTS

A. Prevalent stressors
1. Separation from family members, painful war memories, homesickness, communication problems
2. Up to 49% of refugees evaluated for outpatient treatment have met diagnositic criteria for major depression; more anxiety, dysphoric mood
3. Strong cultural tendency toward somatization
4. Cambodian study: 50% of outpatients diagnosed PTSD

B. Emigration events
1. Involve loss, separation, trauma
2. Associated with depression

C. Acculturation stressors more highly correlated with health problems
1. English skills, socioeconomic status inversely related to psychological problems
2. High resourcefulness, personal master, better social support less depressed, fewer health problems

X. TREATMENT OF MENTAL HEALTH PROBLEMS IN SOUTH-EAST ASIANS

A. Mental health maintained through avoidance of bad, morbid thoughts and exercise of willpower
B> Stigma and shame connected with experiencing mental distress
C. Help-seeking seen as disgraceful, personal sense of failure
D. Importance of understanding, accepting presenting problem
1. Be solution-focused
2. Affirm family, patient are not crazy
3. Acknowledge embarrassment over helpseeking

E. Characteristics of South-East Asian patients in counseling
   1. Communication of satisfaction, dissatisfaction more indirect
   2. Disagreement may not be expressed openly
   3. Minimal self-disclosure
   4. Protection of family members
   5. Restrained expression of feelings
   6. Expect therapist to tell patient what to do
   7. Expect they must exercise self-discipline, willpower in order to get better
   8. Silence in patient often sign of respect, not resistance
   9. Premature disclosure of emotions to stranger seen as lack self-control, cause for shame, betrayal of one's family

F. Useful therapeutic approaches
   1. Find out how similar problems have been solved in culture
   2. Find out what they've already tried that has not worked
   3. Discuss barriers to return in first visit
   4. Reframing to emphasize positive useful since saves face
   5. Use problem-focused, not family-focused approach
      a. family members can be change agents without
      b. accusing them of being part of the problem
   6. Avoid blaming, especially in front of other family members
   7. Quick, tangible, one-shot approaches expected (this is style used in traditional folk healing)
   8. Probing sensitive areas (marriage, sex) should be postponed longer than in Anglo therapy
   9. Look for go-betweens in family system to help affect change, since family members cannot always communicate directly

1. can stand both inside and outside of culture
2. have both deep understanding and critical viewpoint

VII. SOME CONCEPTS REGARDING LATINO CULTURE
- A. La Raza - unity of all Latinos by cultural, spiritual bonds
- B. God controls all events: Latinos more present-oriented than future-oriented
- C. Family loyalty - primacy of family
- D. Respect - accorded on basis of age and gender
- E. Machismo
  1. Men stronger, more reliable, more intelligent than women
  2. Weakness in male behavior looked down on
  3. Females can be strong in their prescribed roles
- F. Compadrazgo - special bond between child's parents, godparents
- G. Helping modalities effective with Hispanics must allow for
  1. Afecto (warmth and demonstrativeness)
  2. Dignidad (dignity)
  3. Fatalismo (fatalism)
  4. Machismo (male superiority)
     - a. should not be equated with inability to express affect
     - b. expression of feeling by men and between men more open in Latino culture
     - c. more male-male touching
  5. Respeto (respect for authority, family, tradition)

VIII. ASPECTS OF THERAPY WITH HISPANICS
- A. Hispanics good candidates for behavioral, family, and networking therapies
  1. Appreciate goal-orientation, straight-forward approach
  2. Difficulties in self-disclosure
  3. One does not reveal personal, family information
  4. Individual goals often subordinate to group goals
  5. Paradox, confrontation may be inappropriate because cause patient to lose face
  6. Mental illness seen as stigmatizing, not possible in "good" families
  7. Main symptoms (anxiety, depression) may be somatized
  8. Importance of non-blaming approach
- B. Specific aspects of therapy
  1. Physical comfort zones closer for Hispanics
  2. Eye contact
     - a. staring rude
     - b. forced eye contact interpreted as loss of respect
     - c. looking subordinate in eye seen as punitive, judgmental
  3. Touch
     - a. more within-sex touching than Anglos
     - b. avoid placing arm on shoulder of Hispanic male patient
  4. Directiveness/Concreteness
     - a. Not being proactive seen as lack of clear helping
     - b. Helpers should ask questions, then generate

suggestions
   c. This must be done without showing disrespect, encouraging submissiveness
   d. Authority figures expected to set limits, offer advice, but patient must make up own mind
   e. Patient wants guidance, structure, advice, without in-depth probing of family problems
   f. Concrete rather than global solutions
   g. Avoid prolonged conversation focusing on future goals or childhood experiences
   h. Gender issues - receiving help from woman professional may be problematic

5. Use of names
   a. Use of first names inappropriate
   b. Formal address preferred
   c. Call people by their right names, correct pronunciation

6. Language
   a. Latino patients consistently rated as more pathological when interviewed by English speakers as opposed to Spanish speakers
   b. Translators may lose nuances of feeling
   c. Dynamics change from dyadic to triadic
   d. Family members may censor, reinterpret
   e. Second language more abstract, detached - less tendency for emotional expression

IX. SOUTH-EAST ASIAN PATIENTS

A. Prevalent stressors
   1. Separation from family members, painful war memories, homesickness, communication problems
   2. Up to 49% of refugees evaluated for outpatient treatment have met diagnositic criteria for major depression; more anxiety, dysphoric mood
   3. Strong cultural tendency toward somatization
   4. Cambodian study: 50% of outpatients diagnosed PTSD

B. Emigration events
   1. Involve loss, separation, trauma
   2. Associated with depression

C. Acculturation stressors more highly correlated with health problems
   1. English skills, socioeconomic status inversely related to psychological problems
   2. High resourcefulness, personal master, better social support less depressed, fewer health problems

X. TREATMENT OF MENTAL HEALTH PROBLEMS IN SOUTH-EAST ASIANS

A. Mental health maintained through avoidance of bad, morbid thoughts and exercise of willpower

B. Stigma and shame connected with experiencing mental distress

C. Help-seeking seen as disgraceful, personal sense of failure

D. Importance of understanding, accepting presenting problem
   1. Be solution-focused
   2. Affirm family, patient are not crazy

3. Acknowledge embarrassment over helpseeking

E. Characteristics of South-East Asian patients in counseling
   1. Communication of satisfaction, dissatisfaction more indirect
   2. Disagreement may not be expressed openly
   3. Minimal self-disclosure
   4. Protection of family members
   5. Restrained expression of feelings
   6. Expect therapist to tell patient what to do
   7. Expect they must exercise self-discipline, willpower in order to get better
   8. Silence in patient often sign of respect, not resistance
   9. Premature disclosure of emotions to stranger seen as lack self-control, cause for shame, betrayal of one's family

F. Useful therapeutic approaches
   1. Find out how similar problems have been solved in culture
   2. Find out what they've already tried that has not worked
   3. Discuss barriers to return in first visit
   4. Reframing to emphasize positive useful since saves face
   5. Use problem-focused, not family-focused approach
      a. family members can be change agents without
      b. accusing them of being part of the problem
   6. Avoid blaming, especially in front of other family members
   7. Quick, tangible, one-shot approaches expected (this is style used in traditional folk healing)
   8. Probing sensitive areas (marriage, sex) should be postponed longer than in Anglo therapy
   9. Look for go-betweens in family system to help affect change, since family members cannot always communicate directly

Cross-Cultural Medical Therapeutics

Clarification of Information

Support/normalization

Reassurance/Reinforcement

Interest in patient as a person

BRIEF COUNSELING STRATEGIES

ADAPTATION OF TECHNIQUES TO INCREASE FAMILIARITY

COGNITIVE REFRAMING

SOLUTION-FOCUSED

SOCIAL SUPPORT

SEARCH FOR MEANING

NARRATIVE THERAPY

UTILIZATION OF COMMUNITY RESOURCES

When Cultures Clash:

Limits to Cultural Relativism

EVALUATING CULTURAL INFORMATION

How true is this cultural stereotype in general?

How well does it apply in this particular case?

What are the actual implications for adjustment of professional practice style in light of this knowledge?

CULTURAL ELEMENTS

(STATIC)

vs.

WORKING WITH CULTURE

(DYNAMIC)

Common Issues

Awareness of one's own culture

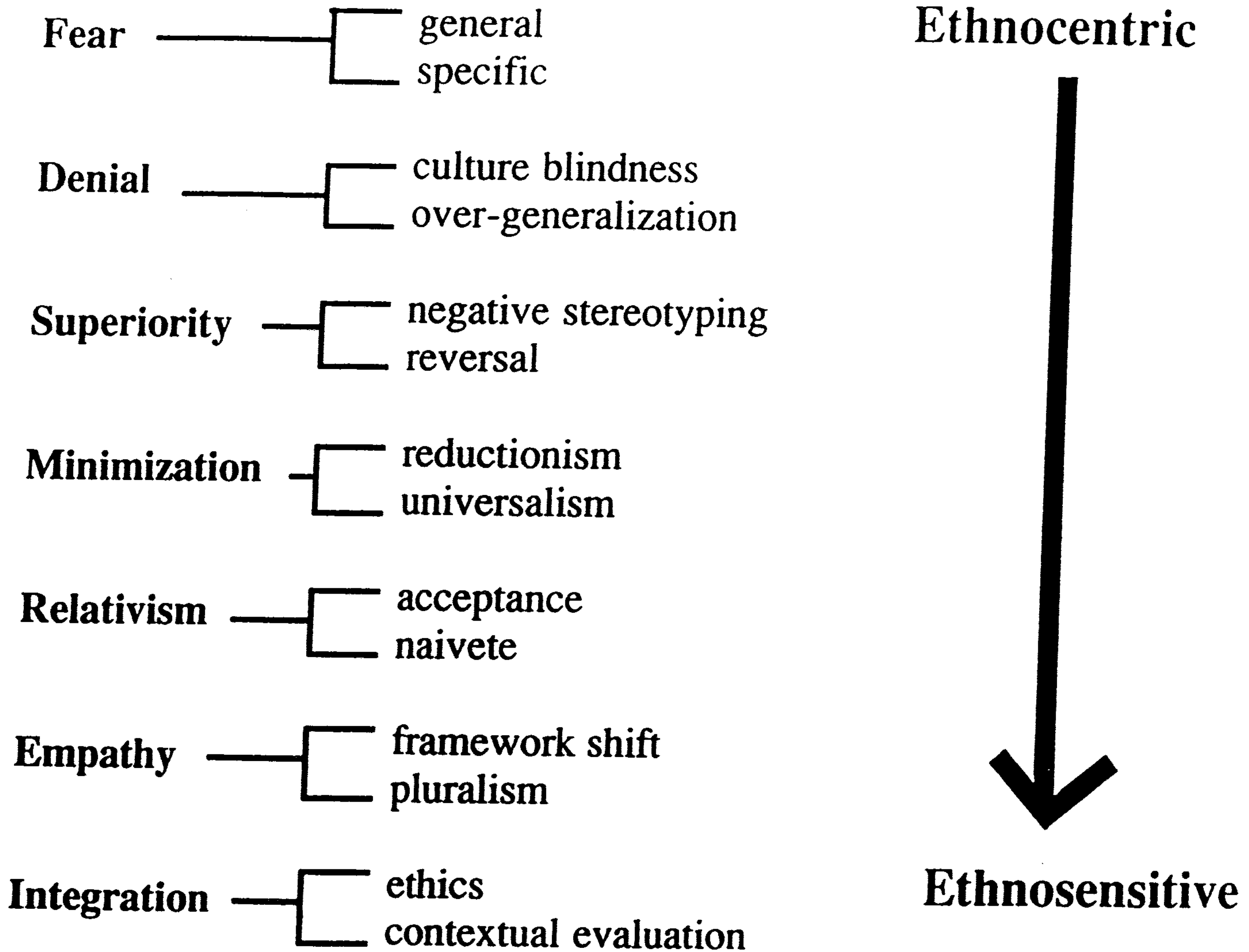
Avoidance of stereotyping, assumptive bias

Rejection of Pseudo-Explanatory Models

Sensitivity to Acculturation Levels

How to Use Culture

Developmental Model of Ethnosensitivity*



*Taken from "A Developmental Model of Ethnosensitivity in Family Practice Training," J. Borkan and Jon Neher, Fam Med 1991; 23:212-7

TABLE 2:

Summary of Strategies Goals, and Content: Development Model of Ethnosensitivity

STAGE	FEAR	DENIAL	SUPERIORITY	MINIMIZATION	RELATIVISM	EMPATHY	INTEGRATION
PRIMARY APPROACH OR STRATEGY	COGNITIVE						
	AFFECTIVE						
				EXPERIMENTAL			
GOALS	Decrease or Eradicate Fear	Promote Recognition of Differences and Ethnicities	Promote Recognition of Similarities	Stress Bio-psychosocial Awareness Debunk "Common Sense"	Promote Cultural Education & Contextual Evaluation Foster Empathy	Facilitate Affective & Experimental Cultural Awareness & Pluralism	Foster Integrative Skills & Multiculturality
CONTENT	Directed Information Balint or Therapy Groups Psychotherapy	Cultural Awareness Activities Broaden Medical Interview	Demystification Inoculation Normalizing Experiences	Biopsychosocial Model Culture Specific Activities Enlightening Experiences	Experiental Learning Cultural Value Games Generalizable Frameworks	Getting out into the Field Intercultural Training & Communication	Experiental Learning & Refinement Medical Ethics

RESIDENT CROSS-CULTURAL TRAINING

Family of Origin Genogram

Cross-Cultural Medicine

Introductory Presentation

Resident Topics

Interpreter Training

Workshop Training

Confidentiality
Topic Sensitivity
Simultaneous Translation

On-the-job Training

Personal nature
Accuracy
Problematic questions
Honesty re: language skills
Observer commentary: bridge

Resident Composition

Year 1: **7 Asian males**
(Korean, Japanese, 2 Philipino, Vietnamese, 2 Taiwanese)
3 females
(Vietnamese, Iranian, German-American)

Year 2: **3 males**
(Philipino, Irish-American, Italian-American)
7 females
(2 Vietnamese, 2 Latina, Philipina, Egyptian, Iranian)

Year 3: **7 males**
(4 Anglo, Taiwanese, Latino, Vietnamese)
4 females
(2 Philipina, 1 Anglo, 1 Iranian-Spanish)

Community Clinic of Orange County

Location: Barrio

Patient Population:
- 50% Latino
- 40% Vietnamese
- 10% Other

Total Annual Patient Visits: 38,771

Total Counseling Clinic Visits:
- 1991-2: 180
- 1993-4: 600

Residents: 30

GENDER & ETHNICITY:

Male: 41% Female: 59%

Age:		
	0-14	38.8%
	15-34	45.7%
	35-64	19.3%
		93.8

BARRIERS TO EFFECTIVE CROSS-CULTURAL COUNSELING

BIAS

1. In interpretation
2. In instrumentation
3. In language
4. In diagnosis & treatment

POTENTIAL OPPRESSION

1. Exploitation
2. Imposition of beliefs
3. Paternalism
4. Stigmatization & Stereotypy

MATCHED vs. UNMATCHED COUNSELING

Cross Cultural Counseling:

Some Basic Principles

Autoplastic - Alloplastic Dilemma

Traditionalism vs. Modernism

Culture Specific
vs.
Universalist

RESOLUTION?

DEFINITIONS

ETHNICITY: Those who conceive of themselves as alike by virtue of their common ancestry, real or fictitious, and who are so regarded by others.

- Shibutani & Kwan, 1965

CULTURE: Highly variable systems of meanings which are learned and shared by a people or an identifiable segment of a population.

- Rohner, 1984

Ss	=	69
$\bar{x}$ age	=	41 (range 14-50 yr)
sex	=	79% female 16% male
ethnicity	=	51% Latino 21% Caucasian 20% Vietnamese 7% other
Diagnoses:		54% Major Depression 20% Anxiety Disorder 26% Adjustment Disorder
Medication:		No medication 77% Medication 23%

(medication status statistically unrelated to diagnosis, ethnicity, or age)

RESULTS

Medicated made significantly more visits than nonmedicated in both pre-counseling ($z = -3.06$, $p <. 01$) and post-counseling ($z = -2.26$, $p < .05$) periods.

Nonmedicated patient showed a significant reduction in both regular ($z = -3.49$, $p < .001$) and urgent care ($z = -1.96$, $p < .03$) visits when comparing pre- and post-counseling periods.

Medicated patients showed a significant reduction in both regular ($z = -1.95$, $p < .05$) and urgent care ($z = -1.83$, $p < .05$) visits, when comparing pre- and post-counseling periods.

Patient Satisfaction (N=25)

1. How satisfied were you with this visit?
   $\bar{x} = 4.2$ sd = .83
2. Did the doctor seem concerned about your problem?
   $\bar{x} = 4.4$ sd = .62
3. Did talking to the doctor help your problem?
   $\bar{x} = 4.0$ sd = 1.0
4. Did the doctor treat you with respect?
   $\bar{x} = 4.5$ sd = .50
5. Was the doctor interested in your family?
   $\bar{x} = 4.1$ sd = .94
6. Would another visit with the doctor be useful?
   $\bar{x} = 4.4$ sd = .62

PATIENT SATISFACTION QUESTIONNAIRE
(N = 88)

42 subjects Spanish-speaking (47.7%)
46 subjects English-speaking (52.3%)

1. Satisfaction with visit:
Little Bit: 2.27%
Somehwat: 13.6%
Satisfied: 42%
Very Satisfied: 40.9%

2. Did doctor care about you?
Somewhat: 3.4%
Cared: 42%
Cared a Great Deal: 54.5%

3. Do you think talking with doctor will help your problem?
Not at all: 2.3%
A little bit: 2.3%
Somewhat: 12.6%
Help: 34.5%
Help a Great Deal: 46%

4. Did doctor ask any questions that were too personal?
Yes 9.2%
No 90,8%

5. Do you feel doctor treated you with respect?
Somewhat: 1.2%
With respect: 35.6%
With a Great Deal of Respect: 63.2%

6. Did the doctor appear to be concerned about your family?
Not at all 4.9%
A little Bit: 2.4%
Somewhat: 8.5%
Concerned: 42.7%
Very Concerned: 41.5%

7. Do you think it would be helpful to come back for another visit with this doctor?
Not at all 1.2%
A Little Bit 2.4%
Somewhat: 3.6%
Helpful: 43.4%
Very Helpful: 49.4%

8. Do you plan to return for a follow-up visit if recommended?
Yes 97.6%
No: 2.4%