5–Part Learning Series
Improving Cultural Competency for Behavioral Health Professionals Serving Public Housing Residents

Learning Collaborative
Session 5
January 6, 2021

NCHPH
National Center for Health in Public Housing

Introductions in the chat

- Name
- Title
- Organization

Welcome

Saqi Maleque Cho, DrPH, MSPH
Director of Research, Policy, and Health Promotion

Fide Pineda Sandoval, CHES
Health Research Assistant

Chantel Moore, MA
Communications Specialist

NCHPH
National Center for Health in Public Housing

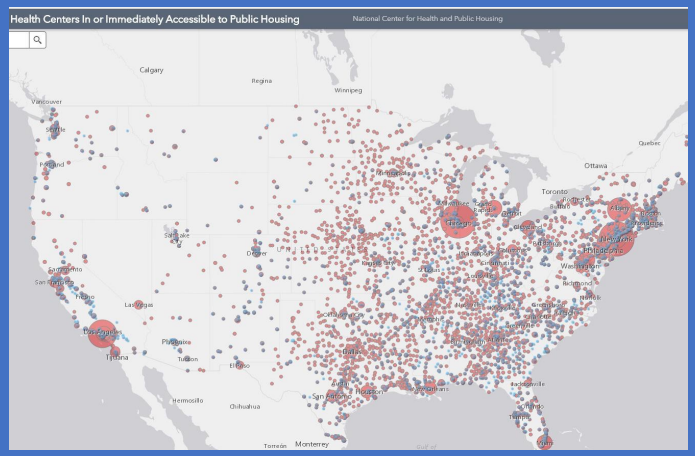
NCHPH

National Center for Health in Public Housing

Strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees.

Training and Technical Assistance | Research and Evaluation | Outreach and Collaboration

info@nchph.org
www.nchph.org



- **Webinars**
- **Monographs**
- **Provider and Resident-Centered Factsheets**
- **Interactive Maps**
- **Training Manuals**
- **Newsletters**
- **Collaboration Guides**
- **One-on-One Matching**

This learning collaborative is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2,004,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Join Us!

Consider minimizing your email

Consider putting your phone away

Consider muting Slack or Teams

Consider anything that will help you be present for the next hour

NCHPH
National Center for Health in Public Housing

Engaging participants through multiple platforms

- **Zoom**
  - Session lecture slides
  - Chat
  - Post – evaluation surveys
- **Moodle**
  - Handouts
  - Power point slides
  - Recordings
- **Mentimeter**
  - Polls
  - Quizzes
  - Videos
  - Case studies videos and audio
- **Breakout Rooms**
  - Group discussions

Course 5 Modules

1. Bridging communication differences to improve engagement
2. Reducing bias in assessment and diagnosis
3. Culturally and linguistically appropriate treatment

How will this material benefit or impact your work?

Video: Using the Cultural Formulation Interview (Introduction)

https://thinkculturalhealth.hhs.gov/behavioral-health/SmallGroup/Facilitator/videos.aspx

1 Bridging communication differences to improve engagement

Communication allows for the exchange of information, feelings, needs and preferences.

Communication can take the following forms:

- Nonverbal
- Verbal
- Written

How we communicate is greatly influenced by our cultural values, attitudes and beliefs.

Communication styles

Culture influences:

- How direct we are when discussing negative or embarrassing information.
- How open we are to talking about personal problems.
- How formal we expect interactions with behavioral health providers to be.
- How important personal warmth and willingness to engage in small talk are to us.

Language assistance services

Ask all clients for their preferred language. If that language is not English, arrange for language assistance services:

Providing a certified interpreter to facilitate any verbal communication between a provider or staff member and a client.

Providing translated materials, including intake forms, consent forms, education materials, and assessment and diagnostic tests.

Which situations require an interpreter?

1. Riya and her teenage daughter are natives of India. Hindi is Riya's primary language, while her daughter is bilingual – fluent in Hindi and English. Riya's daughter attended the counseling session to help interpret between her mother and the counselor.

2. Kevin is an international student from China studying in the United States. Kevin's primary language is Mandarin, but he is also proficient in English. He prefers to receive services in Mandarin.

3. Denise was born in the United States and speaks nine languages. English is her primary language.

4. James was born in the United States and has moderate hearing loss.

5. Claudia was raised in Barbados. English is Claudia's primary language, and she speaks it with a Bajan accent.

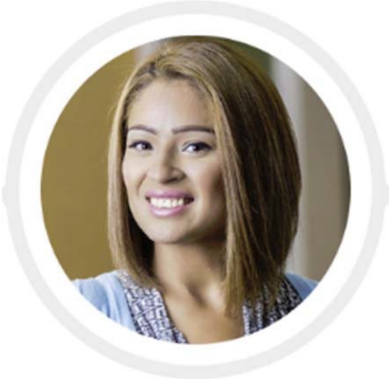
Working with an interpreter

Interpreter

Speaks in the first person. Draws as little attention as possible.

Client

Interacts and speaks directly to you.



Provider

Faces the client and speaks directly to them. Maintains control of the interaction.

2 Reducing bias in assessment and diagnosis

Considering a client's culture and language can improve your ability to make an accurate assessment and diagnosis.

Bias can be inadvertently built into the assessment methods, tools, and approaches we use – even those that are empirically tested.

This is because the people involved in behavioral health research are typically from dominant groups, but what works for dominant groups may not work for every client.

Assessment methods in order of increasing potential for bias

1	Physiological assessment (use of biological markers)
2	Direct behavioral observations (providers' direct observation of clients' behaviors when completing a given task)
3	Self-monitoring (clients' recording of their own behaviors)
4	Behavioral self-reporting scales (instruments that ask clients to recall and report their own behaviors)
5	Clinical interview (structured interview with a provider)
6	Trait measures (self-report instruments that measure personality traits)
7	Self-report of psychopathology measures (self-report instruments that measure clinical diagnoses; e.g., the PHQ-9 to identify depression)
8	Projective tests with structured stimuli (tests such as TEMAS, or Tell me a Story Test, which offer structured visual stimulus cards to elicit story responses that can be used to assess psychological state)
9	Projective tests with ambiguous stimuli (tests that elicit story-style responses to gather information about psychological state using unstructured stimuli; e.g., an ambiguous visual like a Rorschach inkblot)

Is the instrument appropriate or biased?

1. A clinic screens its Spanish-speaking clients, the majority of whom are of Mexican origin, for depression using a Spanish language version of the PHQ-9 that was written and validated in Spain.
2. A psychologist uses the California Psychological Inventory with a client who is a recent immigrant from Thailand and holds a collectivistic worldview. The psychologist finds that the client's scores on some traits are far from the norm.
3. A counselor at a University Health Clinic uses the AUDIT – a provider administered version of a screening instrument to measure alcohol consumption, drinking behavior, and alcohol related problems in adolescents and adults – to assess a 20-year-old, ~~w~~hite, male, English-speaking client for alcohol abuse.
4. A Peruvian client suffering from *susto* is screened for psychopathology using the Minnesota Multiphasic Personality Inventory (MMPI).
5. A counselor screens a Vietnamese speaking client who recently immigrated to the United States for depression using the Vietnamese Depression Scale.

Cross-cultural validity

Validity is how well a measure captures the truth or diagnoses correctly.

-- Green, B. A. (2009).

To understand the flaws of the instruments you are using, ask yourself:

- Who was the instrument developed for?
- What is the potential for bias with this instrument?
- How, if at all, does the instrument take my client's cultural beliefs and practices into account?

Provider bias

Providers can misinterpret clients' behaviors, symptoms, or responses when they hold biases about certain cultural groups or interpret behaviors that they don't understand as pathological. For example:

- A provider with a positive bias about the resilience of African Americans might miss signs of depression in an African American client.
- A provider who doesn't know direct eye contact can be considered rude in Japanese culture may interpret a lack of eye contact from a Japanese client as a sign of psychopathology.

Healthy paranoia

Suspicious or mistrustful attitudes and hypervigilance resulting from lived and historical experiences of racism and discrimination. The term healthy paranoia is used because paranoia can be adaptive rather than a sign of psychopathology in this context.

-- Sims, C. M. (2010).

Healthy paranoia

An elderly African American woman with chronic obstructive pulmonary disorder was admitted to the hospital after showing up in the emergency room with breathing trouble. She refused to let the medical team run any tests because she was afraid that she would die and they would harvest her organs.

A psychiatrist was called in for a consultation. The psychiatrist learned that the patient's husband recently died after being admitted to the hospital for what he was told were routine tests. Worse, the medical team had not explained the tests in a way that the patient was able to understand.

The psychiatrist also learned that, over the course of her life, this patient had heard doctors refer to her as uneducated and difficult. She had raised concerns only to have them be ignored. She had received suboptimal care because of racial bias.

The psychiatrist concluded that her fear of the hospital and of her medical team is rooted in these experiences. In other words, this is a case of healthy paranoia, not psychosis.

Case study – Mr. Flores and Dr. Johnson (Parts 1 & 2)

Mr. Flores is a 45-year-old Salvadorian man who has lived in the United States for two years. Spanish is his primary language, and he has limited English proficiency. Mr. Flores is suffering a great deal of stress as a result of the traumatic experiences that caused him to flee El Salvador and the continued difficulties he and his family face in their new home in Iowa. There is a small but closely knit Latinx community in the mostly white town where Mr. Flores and his family live, with many immigrants like Mr. Flores drawn by the availability of work at a nearby meatpacking plant. However, lately everyone is on edge because of rumors of immigration enforcement raids on factories and plants in the area.

Dr. Johnson is a 32-year-old white man who is a psychiatry resident at a mid-sized hospital in Iowa. Although there are a few small immigrant enclaves near the hospital where he is now completing his residency, he is used to working with predominantly White patients and has limited knowledge of the issues affecting immigrant communities in his town.

3 Culturally and linguistically appropriate treatment

Patient-centered care is providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. To be patient centered, health services must take into account patients' gender, age, sexual orientation, ethnicity, race and social environment and must involve patients and their families in the decision making process.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (2001).

Co-creating a treatment plan

Patient self-management:

- Helps patients identify their problems and gives them the tools to make decisions about how to manage their illness.
- Recognizes that patients are the experts on what inspires and motivates them to make changes to improve their health.
- Offers education about how the therapeutic process works and how therapy aligns with a patient's goals.
- Requires that patients participate in creating their treatment plan.

Explanatory model

Includes the patient's beliefs about his/her illness, the personal and social meaning they attach to their disorder, expectations about what will happen to them and what the provider will do, and their own therapeutic goals.

Kleinman, A., Eisenberg, L., & Good, B. (1978).

The Cultural Formulation Interview

The CFI is a set of 16 questions used to elicit information from clients about their cultural backgrounds in order to improve behavioral health care.

The 16 questions are divided into 4 groups.

1. Cultural definition of the problem
2. Cultural perceptions of cause, context, and support
3. Cultural factors affecting self-coping and past help seeking
4. Cultural factors affecting current help seeking

CFI – Psychosocial stressors module

Socioeconomic status

- Low-paying, sporadic work
- Difficulty affording rent and saving money to send to family

Immigration-related factors

- Children are in Haiti
- Language difficulties
- Discrimination
- No legal residency

Cultural factors

- Haitian spiritual beliefs
- Haitian, non-Western cultural concepts of distress

Depression and Anxiety

CFI – Psychosocial stressors module

These questions will help you understand how psychosocial stressors contribute to Esther's anxiety and depression.

1. Are there things going on that have made your anxiety and depression worse?
2. How are the people around you affected by these [STRESSORS]?
3. How do you cope with these [STRESSORS]?
4. What have other people suggested about coping with these [STRESSORS]?
5. What else could be done about these [STRESSORS]?

Note that once Esther lists stressors in response to the first question, the provider will use Esther's wording instead of saying [STRESSORS].

Cultural adaptation of treatments

The systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values.

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009).

Cultural adaptation of treatments

Changes to engagement can include changing the setting in which a treatment is delivered to make it more accessible or adapting health education components to make them more understandable to individuals with different cultural and linguistic needs.

Changes to treatment delivery can include building in more family involvement, changing the structure of sessions, making materials more plain language, using cultural expressions, and using examples that are culturally specific.

Changes to core components of treatment include adding additional core components or modifying existing ones to make them more culturally appropriate.

Cultural adaptation of CBT for low-income Latinx clients with depression

Latinx clients tend to value personal relationships, so time was allotted for the counselor and client to exchange personal information and discuss issues like culture shock and discrimination that low-income and minority clients often face.

Latinx clients tend to have collectivistic value systems, so the suggestion that clients take time for themselves was modified to a suggestion that clients spend time doing social activities, such as visiting neighbors or going to the park with their families. In focusing on free or low-cost social activities, clients' income status and cultural values were taken into account.

The dominant culture in the U.S. values directness more than most Latinx cultural groups, so clients and counselors discussed phrases that can be used to express respect and still assert oneself, and they talked about strategies for being assertive in situations that may be particularly difficult for low-income Latinx clients (for example with individuals of higher social status).

Counselors used terms that are easier to understand and more culturally relevant. For example, they used "helpful" and "unhelpful" instead of "rational" and "irrational." In recognition of the importance of religion, the common saying "*Ayúdate, que Dios te ayudará"* (Basically, "God helps those who help themselves") was used to encourage clients to complete behavioral homework.

Sue, D. W., & Sue, D. (2016).

Video: Using the Cultural Formulation Interview

https://thinkculturalhealth.hhs.gov/behavioral-health/SmallGroup/Facilitator/videos.aspx

Course 5 Summary

1. Bridging communication differences to improve engagement
2. Reducing bias in assessment and diagnosis
3. Culturally and linguistically appropriate treatment

How will you put this information into practice?

Course 4 Summary

1. Learning about your client's cultural identity
2. Recognizing stereotypes and how they affect behavioral health care
3. Recognizing microaggressions and how they affect behavioral health care
4. Learning about how your clients express distress and seek help

How will you put this information into practice?

Course 3 Summary

1. Increasing awareness of our biases
2. Understanding power and privilege
3. Practicing cultural humility

How will you put this information into practice?

Course 2 Summary

1. Culture, cultural identity, and intersectionality
2. Cultural competency and cultural humility
3. Cultural competency and the workforce
4. Cultural competency and quality of care

How will you put this information into practice?

Earn your credits

1. Log into the participant's website at https://www.thinkculturalhealth.hhs.gov/BehavioralHealth/SmallGroup/

2. Complete the post-Course activities:
    - Confidence scale
    - Test
    - Survey

You will receive your certificate (or statement of participation) by email

Evaluation Survey

National Center for Health in Public Housing

National Center for Health in Public Housing • 2111 Eisenhower Ave, Alexandria, VA 22304 • 703.812.8822 • nchph.org

Contact us

Robert Burns
Director of Health
Bobburns@namgt.com

Dr. Jose Leon
Chief Medical Officer
jose.leon@namgt.com

Saqi Maleque Cho, DrPH, MSPH
Director of Policy, Research, and Health Promotion
Saqi.cho@namgt.com

Fide Pineda Sandoval, CHES
Health Research Assistant
Fide@namgt.com

Chantel Moore, MS
Communications Specialist
Cmoore@namgt.com

Please contact our team for Training and Technical Support
703-812-8822